170		1 - State Amend item 1:	per th g835	9–7-0	tilicate of	Death	ſ	Reg. No.200	2800
	S	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
Physic /Medi		William Michae	1 Haynor					er 2, 20	
Exami		4a. Facility Name (If not institution, give	_		4b. City, Town, o	or Location of Dea	ath	4c. County of	Death
		7391 Hillside Tur			Mount Ai			Freder	
Funeral		Social Security Number 6. Se	x 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hr	1. (Month, Da	y, Year)	 Birthplace (State or Forei Country)
Director		213-48-6403	2 2	53 Yrs.			Sept 27	, 1950	New Jersey
tural', or ttems 23a or 28a-f ahow al Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Lim
faho	0	Maryland Frederic	k Mour	nt Air	V				1 □ Yes 2X
28a-	rect	10e. Street and Number	11041		10f. Zip Code			10g. Citizen of Wh	nat Country?
3a or	0	7391 Hillside Tur	n		21771			USA	
jene. r than "natural", or Items 23s or 28s-f show tre Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of I	lispanic Origin?	Specify Yes or No-		- American Indian,
or the	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, specify Cub 1 □ Yes 2 No		erto rican, etc.)	2.70	White, etc.
E E	by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:		1 1 1 1 1 1 2 2 2 2 4 1 1 0	эрвспу.		Зреспу.	White
nata Nega	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w	orking	16b. Kind of Bus	iness/Industry
E P P	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)					11+111+	Company
Hygiene. other ther ant, tre	S	Z		Servi	ce Techni		ame (First, Middle,	Utility	
	Be	17. Father's Name (First, Middle, Last) Joseph John Hayno	r				_{ame (First, Middle,} th Kearst		,
and Mental Is marked aumatic av	၉								tota Zin Cadal
raun	10.0	19a. Informant's Name/Relationship (T)	. POA/		•		Rural Route Numbe		
t of Heelth and Men If item 27 is marke or other traumatic		Lori Lee Ferguson 20a. Method of Disposition	·		Melinda sition (Name of		onrovia,		ity or Town, State
Department of H Important: If ite any Injury or of once.	ľ	1 Burial 2 Cremation 3 DI	Removal from State	emetery, crei	natory or other pla		ember 3,		
tant		*4 □ Donation 5 □ Other (Specify,			el Cremat				Maryland
Depar mpor any tr		21. Signature of Funeral Service Licens	101-11				ion Servi		
u 2 * u		23a. Part 1. Enter the disease, or comp	MO MO	1251 B	everly L	Heckro	tte, P.A.	Clarksv	Approximate
		shock, or heart failure. List only of	ne cause on each line.					11031,	Interval Between Onset and Deat
ysician		Immediate Cause (Final disease or condition resulting in death)	a. MYOC	ITIZU	AL 1	schem	الہ		Hours
Medical aminer			Due to (or as a consequ		ELION	14			montes
	ē.	Sequentially list conditions,	b. Due to for as a consequ		CLIU	() ;			100001
nsit	듵	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,						
physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
sicier buri	dicai		d						
g phy as the	ed	12.5							
e ettending physicien and of for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		75.tania			23d. Date	of delivery
e ette	Cla	in the past 12 months?	4☐Pregnant at time of de		Ectopic pregnanc Other (specify)	у		Mont	h Day Year
ed by the detached	hys	9 Unknown	9□ Unknown						
een signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of death
o D							. 101	Yes 2□No 3	3 ☐ Probably 4 XUnkn
2 shoul	ompleted						24a. Was autop		ere autopsy findings avail- ior to completion of cause
ž 9	E						perfo 1 ☐ Yes	med? de	ath? ☐Yes 2☐No
e e	e C	25. Was case referred to medical				26. Place of D	eath (Check only o		
w =	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	ner: 4 🗆 Nursing	Home 5 esid	dence 6 Other	(Specify)
r death. ector: After thi by the funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	f 28c. Inju- Wo	ry at rk?	28d. Describe t	how injury occurre	d
death. ctor: Af y the fur	ertification:	2 Accident investigation			M 1	Yes 2 □ No			
24 hours after death. • Funeral Director: A • filled in by the fi	tif E	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
rs att et Di ed in	Cer								
uner uner in lili jet jet jet jet jet jet jet jet jet jet	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina	wledge, deat	h occurred at the ti	me, date and pla	ce, and due to the curred at the time.	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	ed	one	and manner stated.						
hin 24 hours afte the Funeral Dire hpletely filled in I	Σ	29b. Signature and title of certifier	HEGAT!		29c. Licens	se number		29d. Date signed	(Month, Dey, Year)
within 24 h To the Fur completely		P /V/ /	11011		1110	4100	7	7/6/	17 -1
within 2 To the						, ,		, , ,	
within 2		30. Name and address of person who o			Print)	Dai	Parales	well mi	021702
within 2 To the complete		30. Name and address of person who of the control o		mas .	Print)	Drive	Freale	uch mi	0 21702

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	Physicia	20	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	eath Da		ear	3. Time o	
	/Medic		Thomas	Kurt	Harri	son		45 Oib. 7		Logation	of Dooth	August	27	2002 c. County of I		07	′25p ^м
	Examin	er	4a. Facility Name (If no 8306 Ber	-	treet and number)			Park		Location	or Death			altimo			
3	Funeral		5. Social Security Num	nber 6. Sex		e (In yrs. las	t birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth 4/2	29/195		ace (State	or Foreign
7	Director		219-70-60	78 ^{1 💢}	M 2□F 47	-57	Yrs.	MONTHS	Days	Hours	IVIII).	Apr 2		_	1D_	·· y /	
	and		Usual Residence of Do	ob. County		10c. City, 1	Town or Loc	ation							10	Od. Inside C	Dity Limits
	Mary!	tor	MD	Baltimor	e	Park	ville	2								1 🗌 Yes	s 2 ₩ No
	th the or 28a	Director	10e. Street and Numb					10f. Zip	Code				10g. C	itizen of Wha	at Coun	try?	
	23e c		8306 Ber				,		2123					USA			
	er dez	Funeral	11. Marital Status		2. Was Decedent Armed Forces?)	13. V	Vas Deced Yes, spec	ent of H ify Cuba	lispanic Or an, Mexica	rigin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, 1			
336	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show than "natural" or Items 23e or 28a-f show he Madical Examilinate at	by F	1 XNever Married 3 ☐ Widowed 4		1 □ Yes 2 □ If Yes, Give Year or Dates:		1	☐ Yes 2	₹ No	Specify	:			Specify:	whi	.te	
2-0	72 ho	Completed by	1: (Specify	5. Decedent's Educ	ation completed)		16a. Deced	kind of wor	k done d	during mo:	st of work	ing	16b. I	Kind of Busin	ness/Inc	dustry	
121	within ne.	mple	Elementary/Second		College (1-4or	5+)	Fore	OO NOT us	e retirec	d)			Co	nstruc	·tio	m	
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Maryland 21215-0036	lid be lental rkad c	To B	William	Thomas H	larrison					Fra	ances	Frost					
ary	shou and N		19a. Informant's Nam		-							al Route Numb			ate, Zip	Code)	
2	and 2 ealth m 27 i		Ms. Ruby		riend	20h Blad	4715 ce of Dispos			Avenu		Baltimo: Date	_	MD 21 Location - Cit	L206		
lore	iges 1 it of H if ite or oth			Cremation 3 □Re	emoval from State	cen	netery, crem	natory or of	her plac						•		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show eny injury or other traumetic event, the Madical Examility in ust be notified at once.		`4 □ Donation '3 21. Signature of Fune		10	Ches	sapeak							ltsvil	LIE,	MD	
Ba	permi Depa Impo eny ir		1	Shull		M00986						hrmann Drive			MD	2128	26
			23a. Part1. Enter the	disease, or complications. List only on	cations that cause e cause on each	d the death.		er the mode	e of dyin	ng, such as	s cardiac	or respiratory	arrest.	WOOLIG	111	Approxima Interval Be	etween
	Pnysician		Immediate Cause (Fi	nal	Cardi	omegal	Ly									Onset and	J Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):										
		e.	Sequentially list cond if any, leading to imm	nediate III	 Due to (or as	a conseque	nce of):								-		
	executed n and al-transit	Examiner	cause. Enter Underly Cause (Disease or in) that initiated events	ring jury c													
0,	⊕ = :-		resulting in death) La	st	Due to (or as	a conseque	nce of):										
Box 68760	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	an/Medical		d											-		
9 X	certifi nding	/Me	IF FEMALE: 23b. Was decedent p	yearnant 2	3c. If yes, outcome									23d. Date of	of delive	iry	
B	death e atter d for u	iciar	in the past 12 m	onths?	1 Live birth 4 Pregnant a			Ectopic pro Other (sp		<i>y</i>				Month	1	Day	Year
P.O.	that the de led by the a detached t	Physici	9 🗆 Unknown		9□ Unknown							00. 814			4 . 4 . 4		0 طعمدات
	ires the signed d be de	by	Part II. Other signific			but not result	ing in the ur	nderlying c	ause giv	en in Part	l.		Yes	use contribu		ably 4	
orc	w requir been si should	eted	CILLIOSIS	OI LIE I	TTAGT							24a. Wa		7.		psy finding	
Records,	The law cate has t	ompleted										per	opsy formed?	prio	or to cor ath?	npletion of	cause of
		O	25. Was case referre	d to medical						26. Plac	e of Deat	1 X Yes		0 10	Yes	2□ No	
Division of Vital	Physician: this certific	To B	examiner? 1X Yes 2 □ N	H	lospital: 1 Inpat	ient 2 El	R/Outpatien	t 3 DC)A Oth	ner: 4 🗆 N	lursing Ho	ome 5 Res	sidence	XX Other	(Specify	AT	SCENE
0	ding Pt h, After th funeral		27. Manner of Death 1 XNatural	5 Pending	28a. Date of Inj (Month, D	ury 2 ay Year)	28b. Time of Injury		8c. Injur Wor		7Ma	28d. Describe	how inj	ury occurred			
isio	Attending ir death, ector: Aftei by the fune	ertification;	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of Ir	niury - At hom	ne farm str	M eet factory		Yes 2	700	28f. Location	(Street a	and Number	or Rura	l Route Nu	ımber,
Di∨	Dir afte	ertif	4 Homicide	determined	building, e	tc. (Specify)	10, 12111, 011	oot, lactory	, 011100			City or To					
	To the Hospital or within 24 hours afte To the Funeral Dir.	Salc	29a. Certifier 1	☐ Certifying Phys	sician: To the bes	t of my know	ledge, death	occurred	at the tir	me, date a	ind place,	and due to the	e cause(s) and mann	er as st	ated.	n(s)
	Fo the Hos within 24 h Fo the Fun	ledical	one)		and manner s	tated.	on and/or in					190 21 119 1111					
	To the To the Semple	Σ	29b. Signature and ti	tie or certifier	2. (l	10	4.40	290		se number C •M • E				ate signed (AUG, 2			
	U SK M		30 Nama and addition	fonte 11	mpleted cause of	death (Item	23a) (Type,	Print)					- 30	THE STREET		- -	-
	J 62		HAVY DO	UN DI	KOREY				æt,	Balt	imor	e, Mary	ylan	d 2120	1		
	Sta		31. Date filed (Month	0004	82. Regis	trar's Signatu	19 1	par	1/2/								
	Regist	rar	SEP	0 3 2004	1			<u> </u>									

			1 - For State of Maryland /	Department of Health and M Certificate of Death		ene	28003
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death ObSS A M
Į.	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	AUGUST 7	29 2004 4c. County of Deat	
		-	Mercy Medical Cereter	BATIMORS birthday) If Under 1 Year If Under 24 Hrs.	C. Data of Righ		V/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to the security Number 7. Age (In yrs. last to the secur	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign untry) RTH CAROLINA
	and w		Usuat Residence of Decedent	own or Location			10d. Inside City Limits
	a-f sho	ctor	MD. N/A BALT	IIMORE			1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co USA	untry?
	ms 23	neral	201 N. WASHINGTON ST. APT 203 11. Marital Status 12. Was Decedent Ever in U.S.	21231 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menther Hygiene, item 27 Is marked other then "neturel; or liems 23a or 28a-f show other traumatic event, If a Modical Examinations the notified a	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give 3 Widowed 4 Divorced Year or Dates:	tf Yes, specify Cuban, Mexican, Puerio fi 1 ☐ Yes, 2 ☒ No. Specify:	rican, etc./	Black, White	
	'2 hour			6a. Decedent's Usual Occupation (Give kind of work done during most of work)	16	b. Kind of Business/	Industry
Ž	within 7 ane. then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workii life. DO NOT use retired) SUPERVISOR	.9	HOUSEKEER	OTMC
ng z	be filed with tat Hygiene. d other the event, Ire	Be Co	-60- 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		ING
yıar	should be filed within and Mental Hygiene. marked other then umatic event, It e Mental E	To B	FREDERICK COOPER	JESSIE			
Mar	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print) ROMAINE HAWKINS (DAUGHTER)	19b. Mailing Address (Street and Number or Rura 1109 MERIDENE DR. APT		-	
ore,	m 0		20a. Method of Disposition 20b. Place ceme 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	e of Disposition (Name of Disposition or other place)	Pate 20	c. Location - City or	Town, State
Ě	nit. Pages artment of ortant: If it njury or o		*4 Donation 5 Other (Specify) ARBUTI	US MEMORIAL PARK 9-2-2		ALTIMORE,	
n	Department on the concession of the concession on the concession of the concession of the concession on the concession of the concession o		water Skine	1721-27 N. MONROE S			•
t			23a. Par J. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	4	r respiratory arres	t,	Approximate Interval Between Onset and Death
•	Physician /Medical		Immedible Cause (Final disease or condition resulting in death) a	ional Msease			> syears
	Examiner		Sensis	56 01).			2 weeks
	ted nsit	Examiner	Sequentially list conditions, 1 m, 1	ce of			
'n	cate be executed oblysician and the burial-transit	Exar	that initiated events c. Due to (or as a consequence presulting in death) Last	ce of):			
04/80	certificate be executed Iding physician and Ise as the burial-transit	dicai	d				
POX P	leath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dec			23d. Date of del	•
ם כ	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown			Month	Day Year
	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords	w require been sig should b	ted t	corollary artery als	ease	1 ☐ Yes		obably 4 Unknown
Hec	0 L 0	Completed	cercbrovascerar de	Lella-	24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
VItal	ysicien: Th is certificate director, pag	Be Co	25. Was case referred to medical examiner?	26. Place of Death		QNo 1 ☐ Yes	2 NO
> 	Phys this al di	2	1 ☐ Yes 2 ♣No		me 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
0	fter	ation	1(ANatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 □ Yes 2 □ No		,,	
UIVISION	or Atterde directorin by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination				
	thin 24 thin 24 the Fi mpletel	Medical	one) and manner stated.	200 Liganes number		e and place, and due d. Date signed (Mont	Or and the second second
	₹ 3 ± 8		ATTEN DIN	V -		-	
	17		30. Name are address surson who completed cause of death (Item 23)	Ba) (Type, Print)	t Paul Ps	ac. Bal	huire
		ate	31. Date filed (Month, Day, Year) SEP 0 3 2004	The same of the sa		3300	
	Regist	rar	OLITOS ZUU4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARLOW HENDERSON aus 200 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A LEVINDALE NURSING CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-21-1931 9. Birthplace (State or Foreign Country) NORTH CAROLINA 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1√2 M 2□ F 73 242-40-9556 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 1 W. CONWAY ST APT 908 21201 USA Items 23e Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) TRUCKING -8--0-TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be forment of Health and Mental Fourt: If item 27 is marked of HENRY HENDERSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 W CONWAY ST APT 908 BALTIMORE MARY LAND 21201 Date 20c. Location - City or Town, State RUTH D. HENDERSON (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 0 = 0 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or once. 9-3-2004 BALTIMORE, MARYLAND KING MEMORIAL PARK • 4 ☐Donation / 5 ☐ Other (Specify) HIBNER Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. Funeral Service Licensee JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons it and Di ath Immediate Cause (Final disease or condition resulting in death) complications Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAMINED. Date of delivery Month Da The law requires that the death certificate IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 1 Yes 2 No To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 20 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After Certification: Injury 1 Natural 5 Pending 1 Tes UNK death. investigation MARCH 13,2004 SUBJECT Accident 3 Suicide Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 281. Location (Street and Number or Rural Route Number, EUChy or Town, State) SARATORS. BALT MORE, MOD filled in by determined after 4 \(\tag{Homicide}

Division of Vital Records,

State Registrar

Medical

29a Certifier

29b. Signature and title of certifier

1. Date filed (Month, Day, Year)

SEP 0 3 2004

DHMH 17 Rev 1/2001

within 24 hours a To the Funerel C

ORIGINAL

STATION

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of pramination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

SUBWAY

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WERTHEINER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:001 **Physician** Evelyn Patricia Long 2,00 404 0 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimo 059,00 Kosedonte anklin square If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours 64 218-38-4688 27,1939 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State in than "natural", or Items 23a or 28a-f show the Wedical Examinat roust be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Moray Court 21236 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Florist Sales Clerk 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John McClean Mary Caseu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 Patricia Long Hewitt (dghtr) 212 Foxhall Dr., Apt. G, Bel Air, MD 21015 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o once. St. Joseph Church Cem. 9/3/2004 Fullerton, Maryland ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Euneral Service License 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

WowthS Immediate Cause (Final Metastatic Luna Concer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right Breast 1 Pres 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2[] No 2 **□** No 1 Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aff
To the Funeral Di
completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D45390 Angust 31st, 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO MIN(M.D.

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

BALTIMORE

8114 SANDPIPER CIRCLE #211

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 &198 PER FH C835tiff/202/8/4D#4th 2200 Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2004ª AUGUST 31 2:10 A **Physician** LINTON BENNETT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE NORTH OAKS HEALTH CENTER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F MARYLAND 11/20/1907 Director 96 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 Yes 2 No PIKESVILLE BALTIMORE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21208 725 MT. WILSON LANE Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Specify: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOM HOMES SALESMAN 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HERSHMAN LOTTIE LINTON ၉ WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8726 TOWN & COUNTRY BLVD., #205 ELLICOTT CITY, MD. 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is any injury or other traignes. BRIAN A. BLITZ, PER. REP. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Communication 3 Removal from State 20b. Place of Disposition (Name of TOWSON, MD HILLTOP SERV. CORP. 9/1/04 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee PIKESVILLE, MD 21208 8900 REISTERSTOWN RD. euman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Multi-infarct Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnar 3 Ectopic pregnancy Month Dav Year in the past 12 months 1 ☐ Yes 2 ☐ Mo 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Thrising Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 🗌 Yes 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760. P.O. I Division of Vital Records, the funeral director, page 2 should be this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

rai', or items 23a or 28a-f show Examiner must be notified at

"natural"

other than

7 is marked othe traumatic event.

the Medical

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medicai

31. Date filed (Month, Day, Year) SEP 0 3 2004

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King up who sem. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a Certifier

32. Registrar's Signature

25 Main Street - Suite 200, Reisterstown, MD 21136

1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 57465

29d. Date signed (Month, Day, Year)

Mario Alonso Leyva Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-05518 State of Maryland / Department of Health and Mental Hygiene RPD For State Registrar Certificate of Death 1-Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 0824 P ^M Mario Alonso Leyva 26. 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 4823 Berwyn House Road

5. Social Security Number 6. Sex <u>College</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, May 4, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days **Funeral** Months 1938 1X M 2□ F Yrs. 66 213-42-6795 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State ir than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director College Park Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cuba 20740 4823 Berwyn House Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. filed within 72 hours after 1XI Yes 2□ No *Specify:* Cuban 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 by 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist/ Barber personal care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd 2 should be fi Ith and Mental H 27 Ia marked ot traumatic ever Edelmira Leyva . Pages 1 and 2 should by treent of Health and Menta tant: If itam 27 Is marked jury or other traumatic expension. Juan Alonso Zaldivar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 645 Governor Bridge Rd. Davidsonville, MD 21035 Barbara Agnew/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. W. Arundel Crematory 3, 2004 Odenton, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a STAB WOUND 9 Physician CHEST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine -transit death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1XYes 2□No 2 No 1XYes Division of Vital Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 □ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury SVBTECT WAS STABBE D 5 Pending 1 Natural s after dec. FOUND TIP M 1 ☐ Yes 2 🗷 No investigation 2126/04 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 KHomicide 0 47 23 BERWYN HOUSE RO, COLLEGE PARK RESIDENCE To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier August 27, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO, MO ANA 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 5:25PM 31, 2004 Christopher Lakas August Nicholas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 5505 Lake Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F 54 24,1949 Scotland Director 212-58-5032 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Rockville Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 United States 238 5505 Lake Drive death v Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Item any injury or other treumatic event, the Nedical Event 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Musician Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nicholas Eleanor Lakas Nicholas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5505 Lake Drive Rockville, MD Lakas (Wife) 20853 Cynthia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 3,2004 Rockcreek Cemeteries Washington, D.C. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ture of Euneral Service L 21. Sign Rapp Funeral And Cremation Services 933 Gist Avenue Silver Sprign, MD 20910 nter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or near famore. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) Physician 3 Months Non Small Cell Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 X No 1 Tes 2 No 1 Tyes or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 51 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide Hospitel filled 1 B Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9,200 22775 en MI) 16 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) 20850 5454 Wisconsin Avenue, Bethesda, MD Frederick Barr, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra SEP 0 3 2004

DON LONGO 04-05624 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Don Longo AUGUST 30, 2004 4:26P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 116 N.Paca Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01 1/21 1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2□F 56 212-50-1588 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State liem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exartments for notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zio Code 116 N. Paca Street Apt. 126 21201 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1967-73 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n College (1-4or 5+) Elementary/Secondary (0-12) Respiratory Therapist Healthcare permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hygie
Important: If Item 27 is marked other t
any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Scheeler Salvatore Longo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven Longo / Son 164 Branchwood Ct. Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State 04/03/2004 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licenses elver 5311 Edmondson Avenue Baltimore, Maryland 21229 or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications the shock, or heart failure List only one cause of Immediate Cause (Final disease or condition resulting in death) Physician Nerrosdenti /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence off Examiner burial-transit ed by the attending physician and detached for use as the burial-tran death certificate be execu Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of days b? 24a. Was an has autopsy performed? 2 🗆 No 2 ☐ No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 TyYes 2 □ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Atter Division To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29d, Date signed (Month, Day, Year) 29c. License number 29b ature tle of certifier O.C.M.E. AUGUST 31, 2004 ddress of person who cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature 31. Date liled (Month, Day, Year) State SEP 0 3 2004 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death August 31, 2004 8:00 am Francis McOuav 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Bel Air Harford 1408G Bonnett Place If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 14, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1√2 M 2□ F 74 1930 216-24-8804 Vrs Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10h. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Harford Bel Air 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 21015 United States 1408G Bonnett Place 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merifal Sfatus Black, White, etc. Armed Forces? 1⊠ Yes 2 □ No 1948 If Yes, Give Yeer or Detes:to 1952 1 ☐ Never Married 2014Merried 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Chief in the Dept. Labor & Industry 18. Mother's Name (First, Middle, Maiden Surname) State of Md. 12 years 17. Fether's Name (First, Middle, Last) Dorothy (unknown) McQuay Carroll McQuay 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1408G Bonnett Place, Bel Air, Md. 21015 Barbara McOuay/wife 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 9/2/2004 Baltimore, Md. Bayview Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final cane Pani disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably WUnknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical 26. Piece of Deeth (Check only one) examiner? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 27. Menner of Deeth 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No

Physician /Medical Examiner nding physiclen end use es the buriel-transit The law requires that the death certificeta be executed 8-31-04

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couring Mc Bush

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Record

Vital

o

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Heelth and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at

Saltimore, Maryland 21215-0036

Be Completed by Funeral Director

ဥ

Physician/Medical Examiner

edical Certification: To

þ Be Completed

ed by the a been signed by t should be datach After this certificate has been significate has been significated funeral director, pege 2 should the funeral director, pege 2 should the funeral director. or Attending Physician: death. nersi Director: A

To the Hospital within 24 hours a To the Funeral D

after

onth, Dey, Registrar

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

6 Could not be determined

egaelan 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Suite 200 32. Registrer's Signatur

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

(602

29c. License number

D45530

Atwoods

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

Belan HD 21016

08-31-2004

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Magtibau В. Juan 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 7. Age (In yrs. last birthday) Kosedal DOUGLE -ranklin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**∑**M 2□F Days Hours 92 Yrs. 219-94-1364 May 26, Philippines 1912 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "naturel", or Iteme 23a or 28a-f show traumatic event, the Medical Everal er traust be notified at Director Baltimore Maryland | Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number With 9600 Northwind Road 21234 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? yan Magtiba 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Filipino þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Public Transportation 12th Grade Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pablo Magtibay Leoncia Balina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health an
Importent: If item 27 is
any injury or other trau 9600 Northwind Road, Baltimore, MD 21234 Mrs. Sionie Geronimo (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of uneral Service Licensee Dulaney Valley Mem'l 9/4/2004 Timonium, Maryland 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Gause (Final disease or condition resulting in death)

22. Name and Address of Facility Schimunek Fu 9705 Belair Rd., Baltimore,

23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the disease or condition resulting in death) 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of; Examiner Hospitel or Attending Physician: Te law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has pege 2 autopsy performed 2/1 No certificate Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Accident 1 ☐ Yes 2 ☐ No death. after death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Day

29d. Date signed (Month, Day, Year)

(101

1 ☐ Yes 2 ☑ No

2:30

h

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Dr. Kirmans

SEP 0 3 2004

nmed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Dr. Baltimore Md. 21237 Ahmed 32. Registrar's Signature

ORIGINAL

29c. License number 0006133 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Maryland		artment of H		nd Me		giene leg. No./	2001	21	1012
	Dhusisi		1. Decedent's Name (First, Middle	•					2	. Date of Dea Month	ith Day	Year	3. Tin	ne of Death
	Physici /Medio		Charles A. Muhl							Sept.	2, 2			00 A M
*	Examir	er	4a. Fecility Name (If not institution, 8142 Artic Driv		oer)		4b. City, Town, or Pasader		Death			County of Dea Inne Ar		
	Funeral			6. Sex 7	Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	4 Hrs. 8	Date of Birth	[ate or Foreign
3	Director		721-18-0182	1 M 2 □ F	78	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day 12/25/	1925	Phi	ladel	phia PA
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	ecation							de City Limits
	Maryla f sho	ior	MD Anne A	rundel	Pasad									Yes 2∑No
	r 28a	Director	10e. Street and Number	, and a	1 434	acria	10f. Zip Code			1	10g. Citiz	en of What Co	ountry?	
	th with	ai D	8142 Artic Driv	e			21122				U.S	S.A.		
	tems r.m.	Funeral	11. Marital Status	12. Was Deced	es?	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin n, Mexican, I	in? (Specif Puerto Ric	fy Yes or No- can, etc.)	1	4. Race - Ame Black, Whit		n,
36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2√ No	Specify:				Specify: W	hite	
9	be filed within 72 hours after death with the Maryland tall Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Example and the multiple at	ted	15. Decedent	s Education		6a. Dece	dent's Usual Occup	ation			16b. Kin	d of Business	/Industry	
215	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done of DO NOT use retired	during most o	or working					
2	led will led will lygien her the		9 17. Father's Name (First, Middle, L		Ct	naney	Tanks/Ho			Bus.			1 011	Busines
ano	d be find the cod of	o Be	Charles A. Muhl					Emma			Maiden S	ытате)		
Z Z	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ita M.	ĭ	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street			·	r, City or	Town, State, 2	Zip Code)	
Ž,	and 2 eaith a m 27 is		Graceanna Muhl		3	3142	Artic Dri	ive, PA	Asade	ena, MD	211	22		
ore	ges 1 of He if item		20a. Method of Disposition 1√ Burial 2 ☐ Cremation	3 □Removal from SI	0.00	e of Dispo etery, crei	sition (Name of matory or other plac	·	Dat			ation - City or		е
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic. 0008.		*4 Donation 5 □ Other (Sp	ecify)	Mt.					} F	Pasac	dena, M	D	
Bai	permit. Departr Importa any inju		21. Signature of Funeral Service	7 -	1.		2. Name and Addres	_	C+21	llings Pasador	Fune	eral Ho	me, P	·.A.
			23a. Pag1. Enter the disease, or shock, or heart failure. List of	complications that can only one cause on ea	ised the death. [line.	Do not ent	er the mode of dyin	g, such as ca	ardiac or r	espiratory arr	est,	10 2112	Approx Interval	l Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a L	ung	CF	WCER	3						and Death Mow THS
	/Medical Examiner			Due to (o	as a consequen	ce of):								
	· ×	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (o	as a consequen	ce of):			-					
	acuted ind transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.										
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (o	as a consequen	ce of):								
687	ficate physics the	edical		d										
Box	eath certifi attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7F-t				23	3d. Date of del	ivery	
B.	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal de nt at time of death		Ectopic pregnancy Other (specify)					Month	Day	Year
P. O.	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditio	050000		a in the u	ndorkuna cauca au	on in Port I		23e Did to	hannule	e contribute to	the eauce	of death?
Division of Vital Records,	es of pe	by	HYPERTENS		5 E W711		ndenying cause give	en mranti.			es 2			Unknown
cor	w requir been s should	Completed	ATHERUSCO	TIE CARI	DIOVAS	CUL	AR DI	SEN 50	6	24a. Was a	ın	24b. Were au	Itopsv findi	ngs available
Re	The lay	ошь	COW GES-	1.1	1	ILILE		0 1 2		autops perform	med? 2.⊠No	prior to death?	completion 2 \subseteq No	of cause of
ital	ysician: The l is certificate ha director, page	BeC	25. Was case referred to medical examiner?		7,7-1 1 1	10161-	<i>C</i>	26. Place o	of Death (0	Check only on	-	12.700	20110	
<u>5</u>		2	1 ☐ Yes 2 ☐ No				nt 3□ DOA Othe	4 🗀 14015				Other (Spe	cify)	
ono	ding f h. After funer	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig		Day Year) 28	b. Time of Injury	Worl	∕at k? Yes 2∭XNo		d. Describe ho	ow injury	occurred		
Visi	Attanding Physician: ir death. ector: After this certifice by the funeral director, I	ifica	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place o	Injury - At home	, farm, str	eet, factory, office		-			Number or Ru	iral Route I	Number,
Ö	ital or A rs after af Directed in by	Certification:	4 Homicide	Duliding	, etc. (Specity)					City or Town	n, State)			
	To the Hospital or Attanding Ph within 24 hours after death To the Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only ane)	Physician: To the be examiner: On the bas and manne	is of examination	dge, death and/or in	n occurred at the time vestigation, in my of	ne, date and p pinion, death	place, and occurred	d due to the ca at the time, d	ause(s) a ate and p	nd manner as place, and due	stated. to the cau	se(s)
	To the H within 24 To the Fu complete	Me	29b. Signature and title of certifier) 0			29c. License					signed (Monti		
•	\wedge		> M JE	jaloky	^		Dog	7150	103	3	9.	3-0	14	
	17		30. Name and address of persons	- N 1/4	of death (Item 23	a) (Type,	DOC Print) Small	0 1	.1 <	L 1 4	Oct o	Jen.	mD 2	21122
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signature)	11. W. W.	VUC VI	U1 ()	-11-11	.00	1		

	1 - For State Registrar	State of Marylan			of Health an of Death		Reg. No	28013
Physician	1. Decedent's Name (First, Middle, Las	DURANO	MI	CHA	三	2. Date of De	Day Year	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give	e street and number)		4b. City, To	wn, or Location of D	eath	4c. County of Dea	th
	Upper Chesapeak	e Medical Cent	er	Bel	Air		Harfor	ď
Funeral Director	213-30-7027	ex 7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Months E		Hrs. 8. Date of Bi Min. (Month, Di July 2	rth ay, Year) 9. Bir 6, 1932 Ma	thplace (State or Foreign ountry) ryland
pu *	Usual Residence of Decedent 10a, State 10b, County	10c, Cit	ty, Town or Lo	cation				10d. Inside City Limits
r 28a-f show	Maryland Harford		Bel Ai	r				1 □ Yes 2√2 No
or 2	10e. Street and Number	2		10f. Zip C			10g. Citizen of What Co	ountry?
ath w	2726 Conowingo Ro				21015		USA	de la dia
within 72 hours after death with the Maryland within 72 hours after death with the Maryland than "natural" or Items 23a or 28a-f show he Medical Examinar must be notified at maryland	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 (XYes 2 ☐ No If Yes, Give Year or Dates:	Į.	was Deceder if Yes, specify		? (Specify Yes or No uerto Ricen, etc.)	Specify:	
ed within 72 hours af ygiene er than "naturel", or t, the Medical Exam Completed by F	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual (kind of work DO NOT use	done during most of	working	16b. Kind of Business	/Industry
p ba .	11		Troub	le Tecl			Telephone	Company
be filed tal Hygie d other event, I	17. Father's Name (First, Middle, Last)					Name (First, Middle		
should be marked marked matic even	Charles Durand	Michael			Anna	Lucille	Harkins	
0 5 5 5 T	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (S	Street and Number o	r Rural Route Numb	per, City or Town, State,	Zip Code)
Heal Heal tem 2	Gloria Michael / 20a. Method of Disposition 1X Burial 2 Cremation 3 C	20b. F	2726 Place of Dispo cemetery, crea	sition (Name	of	, Bel Air. Date	Maryland 20c. Location - City or	21015 Town, State
Pages nent of l ent: If it	'4 □Donation 5 □ Other (Specif	p) De	er Cre	ek U.M	. Cem. 9	-3-04	Forest Hil	l, Maryland
Dallillo permit. Pages Department of Importent: If i any injury or once.	21. Signature of Funeral Service Licer	isee				Home, P.	A. ngdon, Mary	land 21000
ate be executed ate be executed local Examiner local Examiner	23a. Part. Enter the disease, a common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Indemning Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.	quence of):	0	of dying, such as cal		arrest,	Approximate Interval Between Onset and Death
ite be ysicia ne bur		, d.						
VISION OF VITAL RECORDS, P.O. BOX OR Attending Physicien: The law requires that the death certifical death. ector: After this certificate has been signed by the attending proby the funeral director, page 2 should be detached for use as the fifcation; To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 0 9 Unknown	aldeath 3	Ectopic preg Other (spec			23d. Date of de Month	livery Day Year
tuires that a signed to all be deticated by PI	Part II. Dther significant conditions of	contributing to death but not res		nderlying cau			tobacco use contribute t Yes 2 \(\text{No} \) \(3 \text{\$\pi\$} \) P	
II KECOIGS, The law requires to cate has been signe page 2 should be completed by							s an 24b. Were a prior to death? 2 No 1 \(\) Yes	utopsy findings available completion of cause of s 2 \sum No
VITAL P. sicien: The scertificate lirector, pag	25. Was case referred to medical				26. Place of	Death (Check only		, , , , , , , , , , , , , , , , , , , ,
NY VITAI Ko hysicien: The his certificate hall director, page To Be Com	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA	Other: 4 Nursi	ng Home 5 ☐ Res	idence 6 □Other (Spe	ecify)
ION OF nding Phys th.: After this e funeral di	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Linjury at Work? 1 ☐ Yes 2 ☐ No	-	how injury occurred	,
Division c bit or Attending P rs after death. al Director: After t ed in by the funers Certification;	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, o	office		(Street and Number or Rown, State)	ural Route Number,
DIVISIC To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	29a. Certifier (Check only one) Certifying Pt 2 Medicel Exer	nysician: To the best of my kn niner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at vestigation, in	the time, date and p my opinion, death	place, and due to the occurred at the time	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
To th To th To th	29b. Signature and title of certifier	-MD			icense number	07	29d. Date signed (Mon August 31	
18	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	Rd. #			
State Registrar	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign		hands				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** August 723AM **ESTERVINA** 2004 MARTNO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BFI AIR
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. UPPER CHESAPEAKE HOSPITAL HARFORD CO 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 2, 1957 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 47 Yrs. Director 584-82-5124 PUERTO RICO Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28e-f show 1 ☐ Yes 2 🛛 No Director MARYLAND HARFORD ABERDEEN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 734 CUSTIS ST 21001 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2□ No Specify Puerto Rican þ Specify: PUERTO RICAN 3X Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade COOK/HOUSEKEEPER h and Mental Hygie APG 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If I tem 27 Is marked ony injury or other treumetic ew. SIGS. ည ADOLFO SANCHEZ COLON ESTHER LOPEZ RIVERA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Marino Jr./Son 734 Custis St., Aberdeen, Md., 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State *4 □ Donation 5 □ Other (Specify) HARFORD MEMORIAL 09-04-04 ABERDEEN, MARYLAND 21. Sign vure of Fugeral Service Licens 22. Name and Address of Facility WM C 321 C BROWN COMMUNITY FUNERAL HOME-HARFORD S PHILADELPHIA BLVD., ABERDEEN MD 21001 Davara omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 232. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) metastatic Breast **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2140 Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 2 ER/Outpatient 3 DOA I Director: After the in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier m - D -August 30th, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MYO MIN (M.D.) 602 South Atropped Road #200, Bel Air, MD 21014 31. Date filed (Month, Day, Year) SEP 0 3 2004 32. Registrar's Signature State Elected A Species Registrar

DHMH 17 Rev 1/2001

MR#41997

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of H rtificate of L		Reg. M	(D) (D) (1)	28015
	Physici		1. Decedent's Name (First, Middle, Las PAVLE 175		MOR	RELL			Day Yeer 3/ 2004	3. Time of Death 3:20 PM
	/Medic Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	
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	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birthday 60 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign ountry)
	Director		215-40-3532 Usual Residence of Decedent		00 113.			AUG 4 194	4 MAR	YLAND
	nylanc thow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Directo	MARYLAND N/A		BALTIM			·····		1 XYes 2 No
	with t	Ē	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	ountry?
	death ms 23	era	1555 LOCHWOOD RI	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	U.S.A.	rican Indian,
မွ	or Ite		1 ☐ Never Married 2 🏋 Married	Armed Forces? 1 Yes 2 X If Yes, Give	10	If Yes, specify Cuba 1 ☐ Yes 2 XNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
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	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, the Me	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maide	en Sumame)	
yla	ould I Meni	L _O	unknown/ GLENWOOI				GLADYS			•
Maryland	d 2 st th and 17 is n treum		19a. Informant's Name/Relationship (7					al Route Number, City		
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I them 27 is marked other than "neturel", or tlems 23e or 28e-1 show them than "neturel", or tlems 23e or 28e-1 show to other treumatic event, the Medical Examinar must be notified at		William Morrell S 20a. Method of Disposition		20b. Place of Disp	osition (Name of		cimore, Mai	ryland 21 Location - City or	
Baltimore,	Page ento nt: ff ry or		1 \(\Display \) Burial 2 \(\Display \) Cremation 3 \(\Display \) 1 \(\Display \) Donation 5 \(\Display \) Other (Specify		MT ZION	matory`or other place CEMETERY	09-04	-04 TANI	OCIO GINE	MARYLAND
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	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):					
68760,	icate be executed physician and s the burial-transit	Ical		. d	a consequence on.					
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al Reco	The larate has	Completed						24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
VIII.	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner?	Hospital:		Othe		(Check only one)		
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director,	atlon: To	27. Manner of Death 154. Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier y Year) 28b. Time o	f 28c. Injury Work	at Nursing Hor	me 5 Residence 28d. Describe how inj		sify)
Divis	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funers	Certification:	3 Suicide 6 Could not be determined	building, etc				28f. Location (Street a City or Town, Sta	te)	
	Hosp 24 hoi Fune stely fi	Medical	29a. Certifier TS Certifying Ph (Check only one)	ysicien: To the best on niner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the cause(ed at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier			29c. License			ate signed (Month	
	/		> Manisho!	Saul	, MD	Do	058913	Ava	US7 3	1 2004
	h		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print) ARITA	tn 56	oi Loca	+ RAVE	N BOULEVAN
	J		30. Name and address of person who of MAN i SHA BY 31. Date filled (Month, Day, Year)	HHL, MD	HO Size	SPITAL		BACT	imorE,	MARYLAND
	Sta Registr	. a. s.	SEP 0 3 2004	32. Registra	ar's Signature	(i)				21239

			For State Registra AMEND ITEM #2	State of Maryl				• •	0.0	01	00016
	g		Decedent's Name (First, Middle, Last)	PER PHY G	836 10/2	9/64°SH' D	Jan	2. Date of Dea	ath 31 Day	114.	3. Time of Death
	Physicia /Medic		Ada M.	Mah	ner			August		Year 2004	9:30 a ^M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Lo	ocation of Death			nty of Death	
			Heritage Harbour			Annapoli				e Aru	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	v. Year)	Cou	place (State or Foreign
			Usual Residence of Decedent					march 1	0, 192	ı wası	hington, DC
	show		10a. State 10b. County	100	. City, Town or Lo	ecation					10d. Inside City Limits
	8e-f	Director	MD Anne Arui	ndel	Annapo]						1 ☐ Yes XXNo
	with to	Dir	10e. Street and Number	D1		10f. Zip Code			10g. Citizen o	f What Cou	intry?
	ns 23	Funerai	84 N. Old Mill Bot	2. Was Decedent Ever	in U.S. 13. 1	21401 Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Sp	ecify Yes or No-	USA 14. R	ace - Ameri	can Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mealth Hygiens. I them 27 is marked other then "neturel; or liems 23a or 28e-f show other treumetic event, Ita Maritial Evanting must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Mexican, Puerto Specify:	Rićan, etc.)	Spec	lack, White,	, etc. White
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Maryland	2 should and Men is marke eumetic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street and				n, State, Zij	o Code)
	1 and 2 Health tem 27 i		Fred Franke (Person		77 F	ranklin St					
ore	Pages 1 nent of H ant: If ite ary or oth		20a. Method of Disposition		b. Place of Dispo cemetery, crer	sition (Name of natory or other place)		Date	20c. Location	n - City or T	own, State
Baltimore,			4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service © censes			oln Cem.	9-4-		Brent	vood,	MD
Ba	permit. Departr Importe eny inje		1 2 Cm		22	Hardesty 12 Ridge1	Füneral v Avenu	Home, l	P.A.	MD 21	401
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the o	death. Do not ent	er the mode of dying, s	such as cardiac	or respiratory are	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):						
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58760,	cate be executed physician and the burial-transit	dicai	d.							-	
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ion	Attending Is death. ector: After by the funer.	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	Work? M 1 ☐ Yes	2 □ No				
Division	F 9 F C	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (S City or Town	treet and Nun n, State)	nber or Rura	al Route Number,
	To the Hospitel o within 24 hours af To the Funerel Di completely filled in	edical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, death	n occurred at the time, ovestigation, in my opinion	date and place, on, death occur	and due to the c	ause(s) and r late and place	nanner as s	tated. o the cause(s)
	Fo the within Fo the comple	Mec	29b. Signature and title of certifier	and married stated.		29c. License nu	umber	2	9d. Date sign	ed (Month,	Day, Year)
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	10		30. Name and address of person who com	D UD KI	Item 23a) (Type,	VESTF731	TUNP	POLIS	mD.	214	01
			31. Date filed (Month, Day, Year)	32. Registrar's S	ignature		•	1	· · · · · · · · · · · · · · · · · · ·		
	Sta Registr		or sate med (mornin, say, roar)	32. Registrar s s	and the same						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Boonsong Meesiri 30 2004 10:50 a^M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Months 215-74-0787 Yrs 75 Director June 6, Thailand Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28e-f show treumatic evant, the Medical Examiner must be notified at Director 1 ☐ Yes XX No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1841 Shively Court Thailand Items 23a 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo Specify: 2 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dang Meesiri Patoom Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Ia m any injury or othar treum once. Jittipon Meesiri (Son) 1841 Shively Court, Annapolis, MD 21401 20a. Method of Disposition
1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9-7-2004 * 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Dic 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arcinema mondes /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy įō in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 90 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 3 No 1 Yes the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2/2 No 2 1 🗌 Yes 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 - Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 \ Homicide within 24 hours a To the Funeral D 29a. Certifie 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie -30, D0811 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BESTGATE YLO Yno 910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylar	-	artment of H			giene Reg. No.2004	28018
<u>></u>	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last	Bessie	///	Nelso 4b. City, Town, o	or Location of		. Day . Year	3. Time of Death 13:10 p M
	Funeral Director		5. Social Security Number 6. S 473-09-7633	□M 3Ω/E	last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bir Min. (Month, Da Nov. 4		rthplace (State or Foreign Jountry)
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, it a Medical Exercise must be notified at 900c.	To Be Completed by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Howard 10e. Street and Number 6753 Flapjack Lar 11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced 15. Decedent's English only highest grave Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Richard Henry Gree 19a. Informant's Name/Relationship (Kathy Hofer/daugh 20a. Method of Disposition 1 Buriel 2 XCremation 3 Name/Relationship (Specify 21. Signature of Funeral Service Licer	Collect 12. Was Decedent Ever in Under Forces? 1	16a. Decec (Give life.) Assemb	Nas Decedent of H Yes, specify Cub 1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retire Dly Line Ing Address (Street Flapjack sition (Name of matory or other pla el Cremat Name and Addres Ing Home	Specify: Dation during most of during most of the second land Number Lane Copy Second land Specific Crema	's Name (First, Middle Le Alberta Tor Rural Route Numb Columbia, Date eptember 2 2004	Factory Maiden Sumame) Rudesill er, City or Town, State, Maryland 2 20c. Location - City o Odenton, M Lee P.O. B	rerican Indian, ite, etc. hite kite kindustry Zip Code) 1046 r Town, State aryland
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O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
ecords, P	requires een sign rould be	þ	Part II. Other significant conditions o	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use contribute Yes 2 No 3 ☐ P	to the cause of death?
Vital Rec	The la ate has page 2	e Completed	25. Was case referred to medical				26 Place		psy prior to ormed? death? 2 No 1 □ Ye	utopsy findings available completion of cause of s 2 No
ō	ling Phys I. After this uneral di	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	ER/Outpation 28b. Time of Injury	28c. Injui	ner: 4 🗆 Nurs	sing Home 5 Resi	dence 6 Other (Spendown injury occurred	ecity)
DIVISION	- 9	Certification;	3 Suicide 6 Could not be determined	building, etc. (Speci				City or To		
	To the Hospital of within 24 hours aft to the Funeral Discompletely filled in	Medical	(Check only 2 Medicel Examone) 29b. Signature and title of certifier	ysician: To the best of my kniner: On the basis of examiniand manner stated.	ation and/or inv	vestigation, in my o	opinion, death	occurred at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mon August Lisable	e to the cause(s) th, Day, Year)
	Sta	ite	30. Name and address of person who Su 2 cm Hb a 31. Date filed (Month, Day, Year)	0,5005	519.		zell L	in-lla	charlle	MD21039
19	Registi	ar	SEP 0 3 200	Straw D	400					

			State Registrar	ate of Maryland		artment rtificate			and M		giene	the Property of	28019
п	Physici	an	1. Decedent's Name (First, Middle, Last)	ia Oundonf	£					2. Date of Dea	30°, 200	X eer	3. Time of Death 10:55 AMM
	/Media	cal	Jacqueline Lou 4a. Facility Name (If not institution, give stree		T	4h City 1	OWD OF	Location o	of Death	August	4c. County of		TO: 33 AI'M
	Examir	ıer	Frederick Memoria				eder		n Deali		Fred		k
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth June 18	1	9. Birthp	place (State or Foreign
	Director		216-30-3540	² X ^F 72	Yrs.	WIGHTE	Days	110013	(VIII t.	June 18	7, 1932	Mar	"YLand
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation						1	10d. Inside City Limits
	Many a-f sh	ģ	Maryland Frederick	Fr	ederi	ck							1 XYes 2 No
	or 28	Direc	10e. Street and Number			10f. Zip					10g. Citizen of W		ntry?
	s 23e	ral	17 Hamilton Avenu				701				U.S.A		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28a-1 show or other fraumatic event, If a Madical Exac	Completed by Funeral Director	A	Vas Decedent Ever in U.S. rmed Forces? □Yes 2X No Yes, Give 'ear or Dates:	- 1	Vas Decede f Yes, speci I ☐ Yes 2		spanic Orig , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	white,	
5-0	72 ho	eted	15. Decedent's Educatio (Specify only highest grade con	n npleted)	16a. Deced	lent's Usual kind of work DO NOT use	Occupa	tion urina most	of worki	na	16b. Kind of Bus	siness/In	dustry
121	within ane. than	dm		college (1-4or 5+)		ро мот usi Beaut:					Hair	Carc	
d 2	filed Hygis other ent, II	Be Co	17. Father's Name (First, Middle, Last)			Deaut.		18. Mothe	r's Name	(First, Middle,	Maiden Sumame		·
<u>lan</u>	uld be Aental rked o	To B	William T. Wh	itmore				Le	ena (\uinn			
, Maryland	and 2 should I		19a. Informant's Name/Relationship (Type, F Mr. Hiley A. Orndor		19b. Mailin 17 H	g Address amilt	(Street ar	nd Numbe	Frec	derick,	r, City or Town, S Marylan	itate, Zip d 2	1701
Baltimore,	Part and		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	cen	ce of Dispo netery, cren nt Oliv	natory or oti	ner place	" Sept		2004	20c. Location - C Frederi	•	own, State Maryland
Balt	permit. Pa Depertmen Importent: any njury once.		21. Signature of Funeral Service License	MO02	55 K	Name and eeney 06 Ea	and st_C	of Facility Basf hurch	ord St.	PA Fune	eral Hom erick, M	e D 21	701
8760,	Americal Examiner Physician and hysician and hysician in the burdal-fransit	dlcal Examiner	23a. Pant1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseque	Do not enter Lory ince of):	er the mode	of dying	, such as o	cardiac o	or respiratory and	rest,		Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	yes, outcome of pregnanc □ Live birth 2 □ Fetal di □ Pregnant at time of dea □ Unknown	eath 3 🗆	Ectopic pre					23d. Date Mont		ery Day Year
rds, P.	equires that en signed b ould be deta	by	Part II. Other significant conditions contribu	ting to death but not resulti	ing in the ur	idertying ca	use giver	n in Part I.		23e. Did to	N	bute to th	ne cause of death?
Vital Record		Completed								24a. Was a autops perform	sy pr med2* de	ere autorior to constath?	psy findings available mpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	Check on or			
of	. is is	2	1 ☐ Yes 2 No Hospii 27. Manner of Death 28	1 Inpatient 2	WOutpatient			4 LI NUI			ence 6 Other		y)
	ding I h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	8b. Time of Injury	M 28	C. Injury : Work?	at P es 2.∐N		28d. Describe h	ow injury occurre	3	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 □ Suicido 6 □ Could not be	e. Place of Injury - At hom- building, etc. (Specify)	e, farm, stre				-	28f. Location (Si City or Town	treet and Number n, State)	r or Rura	l Route Number,
	pital ours as		29a. Certifier Certifying Physicier	. T					+				
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Examiner:	 To the best of my knowled on the basis of examination and manner stated. 	edge, death n and/or inv	estigation, i	n my opi	, date and nion, deatl	d place, a h occurre	and due to the cored at the time, d	ause(s) and man ate and place, ar	ner as st id due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		~	29c.	License	number		2	9d. Date signed	(Month, I	Day, Year)
	(1-/20		NJ		D 41	866			August	31,	2004
	V		30. Name and address of person who comple Kanan Hudhud, M.D.	, 46-B Thoma	s Joh	nson	Driv	e, Fr	ede	rick, Ma	aryland	217 0)2
:	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 3 2004	32. Fegistrar's Signatur		order.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00 P.M durarco 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE
If Under 1 Year | If Under 24 Hrs. LOCK aven SALTIMORE 5. Social Security Number ge (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F 76 Yrs. Days Min 039-12. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or itams 23a or 28a-f show Examiner must be notified at To Be Completed by Funeral Director BAL 1 Yes 2 No MALTIMORE TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No IfYes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) obert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ABurial 2 ☐ Cremation 3 Removal from State Coneteru * 4 □ Donation 5 □ Other (Specify) 22. Name and Address / Facility BALTIMORE MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): month disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physiclan/Medical Examiner Due to (or as a consequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4☐Pregnant at time of death Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: \(\sum_\) Nursing Home 5 \(\sum_\) Residence 6 \(\sum_\) Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 1 🗍 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maining as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

within 24 hours after death

To the Funeral Director:
completely filled in by the

EDWARD.

State Registrar

DHMH 17 Rev 1/2001

SEP 0 3 2004

MANITHA RAYMUNDO.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

560140 Claraven

			4 For	State of Maryland / De	partment of Health and N	-	_	
			1 State Registrar		Certificate of Death	Reg	3. No. 0 0	28021
	Physic		1. Decedent's Name (First, Middle, Las.	PARKER		2. Date of Death Month	Day Year	3. Time of Death 9.35 AM
	/Medi		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	SEPTEMBE		
	Exami	ner	NORTHWEST	HOSPITAL	n	200	4c. County of Death	
	Funeral		5. Social Security Number 6. Se		ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	TIMORE uplace (State or Foreign
	Director		238-16-2981 13 Usual Residence of Decedent	M 2□F 82 Yrs	Months Dave Hours Min	8. Date of Birth Month, Day, Y	1922 NOR	TH CAROLIN,
	larytan show	2	10a. State 10b. County	10c. City, Town or	0	. 1	1	10d. Inside City Limits
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "naturel", or flems 23a or 28a-f show other treumatic event, the Medical Evand eartmat be notified at	Funeral Director	10e. Street and Number	14	SALTIMOR 10f. Zip Code	100	g. Cityzen of What Cou	1 XYes 2 No
	3a o		3212 MAVE	EDIR RAAN	7/20	7	USA	
	death	Jere	11. Marital Status	12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (Sp.	ecity Yes or No-	14. Race - Amer	
9	after or fte	Ē	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
93	rel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	AC. K
215-0036	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ina 16	6b. Kind of Business/Ir	ndustry
12	Mithin De.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	a. DO NOT use retired)	9		
121	iled v fygie her t		17 Fathoda Nama / Gina Aliddle / and	TYRS	DRIVER			TATION DEPT
anc	ould be filed within I Mental Hygiene. Rerked other than latic event, the M	Be	17. Father's Name (First, Middle, Last)	C	18. Mother's Name	e (First, Middle, Ma	uideń Sumame)	
2	should nd Men marke umatic	2		JALLOWAY M	ARKER ESTE	LLA	KING	SEY
Maryland	12 sho h and 7 Is ma treuma		19a. Informant's Name/Relationship (T)	vpe, Print) 19b. Ma	ailing Address (Street and Number or Run	al Route Number, C	City or Town, State, Zi	p Code)
	1 and Health em 27		20a. Method of Disposition	EKER (WIFE) 5	Sposition (Name of	Date 20	THORE, M	021207
کر	0 U L		1 Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemetery, o	rematory or other place)		c. Location - City or T	
Baltimore,		1 8	'4 Donation 5 Other (Specify)	I OTAK I	SON FOREST 109-0	27-040	WINGS M	ILLS, MD.
Ba	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	Williams	22. Name and Address of Facility BI	AVE X	R. FUNE	RAL HOME
П			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	lications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PULMONA	24 EMBOLIS	n		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	LAGITITICI	L	Sequentially list conditions,	b				
	be sit	Examiner	Sequentially list conditions, if any, Isaam to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).				
	and and -tran	кап	that initiated events resulting in death) Last	Due to (of an a construction)				
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8760	physi the t	dical		d				
9 ×	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	IF FEMALE:	12a If upa outcome of				
Вох	atten for us	ian	in the past 12 months?		3 □Ectopic pregnancy		23d. Date of deliver	ery Day Year
	at the de by the a stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death ! 9□Unknown	5 Other (specify)		N G G G	Duy Toal
P.0	that the part of t		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I	23a Did tohan	co use contribute to the	ha dayon of death?
Records,	es ob pe	d by	PHEUMON		and any mig decided give in it with		2 □ No 3 □ Prot	
Ö	w requir been s should	ete	11-21,000			10.163		
ě	has has	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	10 -					performed 1 ☐ Yes 2 ☑	d? death? Prio 1 ☐ Yes	2 No
Vital	tending Physicien: death. tor: After this certific the funeral director.	Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death	(Check only one)		
ō	Phys rthis rat di	2	1 Yes 2 No	1 2 npatient 2 ER/Outpati 28a. Date of Injury 28b. Time			e 6 Other (Specif	y)
S F	ding h. Afte fune	tlon	Natural 5 Pending	(Month, Day Year) Injury	Work?	28d. Describe how i	injury occurred	
DIVISION	ol or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,		196 I apption (Ctros	4 and 4 (makes a 2 a m	
\leq	after after Dire	erti	4 Homicide determined	building, etc. (Specify)	stroot, ractory, onlice	City or Town, S	t and Number or Rura itate)	u Houte Number,
	Hospitel or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune		29a. Certifier	sician: To the hest of my knowledge, de	ath occurred at the time, date and place, a		/)	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examination)	ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
	ro the complete compl	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
				1 My	D54352		PTEMBER	
	X.		30. Name and address of person who co	impleted cause of death (Item 23a) (Type				
	10,		DR. MIRCEE ?	TODOR 5401	MIN COURT PA	TOWSO	N MD.	21204
	Sta		31. Date filed (Month, Day, Year)	. negistrar's Signature	<i>M</i> .	/	1, 10.0	/
	Registr	ar	SEP 0 3 2004	Blow to Apr	war			

			1 - State Registrar Co	partment of Health and Mertificate of Death	Mental Hygiene
	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
	/Medic	cal	William James Pendergast	45 City Taran 1 - 1 - 1 - 1	September 2, 2004 6:05 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) 713 Dunkirk Rd.	4b. Cily, Town, or Location of Death Baltimore	4c. County of Death Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	
	Director		215-07-1472 1XM 2□F 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 9, 1919 9. Birthplace (State or Foreign Country) Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Maryli 1 sho	ō	Maryland Baltimore Baltin		1 ☐ Yes 2 🏹 No
	r 28e	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with	alD	713 Dunkirk Rd.	21212	United States
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene is marked other then "neturel", or Items 23e or 28e-1 show aumatic event, It a Medical Extrained to a clifted at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Woldowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 No If Yes, Give Year or Dates: 1943–45	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white
9	2 hou	ted	15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b Kind of Business/Industry
21215-0036	thin 7	nple	(Specify only highest grade completed) (Gillie Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of worki . DO NOT use retired)	ing
	filed w Hygien other th	Cor		pervisor	insurance
anc	d be findal H	Ве	17. Father's Name (First, Middle, Last) Thomas Henry Pendergast		e (First, Middle, Maiden Surname) na Mary Meister
Maryland	should nd Men marke ımaric	2			al Route Number, City or Town, State, Zip Code)
M				2 Park Village Rd.	San Diego, CA 92129
ore,	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene If item 27 is marked other then "netun or other treumatic event, its Medical		20a. Method of Disposition 1	position (Name of Ematory or other place)	Date 20c. Location - City or Town, State
3altimore ,	Pages ment of I tent: If its jury or o		*4 Donation 5 Other (Specify) Dulaney V	alley Mem Gar.Sept.	8,2004 Timonium, Maryland
Ball	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		John C. Toward	OJOU TOLK KQ.	feld Funeral Home, Inc. Baltimore, MD 21212
	Physician /Medical		23a. Pand Enter the disease, or complications that caused the death. Do not e stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac of	Prespiratory arrest, Approximate Interval Between Onset and Death
8760,	eate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c	erotic Vasanl	an diverse 15 yr
P.O. Box 68	law requires that the death certifica as been signed by the attending pr 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	equires that en signed to ould be det		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown
al Records,	The ate h	e Completed by			24a. Was an autopsy performed? 1 ☐ Yes 27 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 27 No
Vital	Physicien: this certific ral director,	O B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death ent 3 DOA Other: 4 Nursing Hor	me
ion of	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. injury at 2	28d. escribe how injury occurred
Division	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or within 24 hours afte To the Funerel Director completely filled in the Funerel Director of the Funerel Direc	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dead on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	To T com	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	10		Waiel Jamera, M.V.	V5'20/6	7/7/04
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type Waiel 206 E. 21 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nd Street,	# (50, 20 Wimo Le, Mo ~1218
• 9	Sta Registr		SED 0.3 2004	Spark	

			1 - For Stata Ragistrar	State of Mary		artment of <i>rtificate o</i>		-	giene Reg. No. () ()	L 28023
	Division		1. Decedent's Name (First, Middle, Las	()				2. Date of De	ath	3. Time of Death
	Physic /Medi		Donald	Theodore	Po	st		Septem		^{Year} 004 7:48 a ^M
	Exami	ner	4a. Facility Name (If not institution, give Anne Arundel Me		r		, or Location of D ${ t polis}$	eath	4c. County o	
	Funeral Director	10	5. Social Security Number 6. Se 225-50-9017	7. Age (lr	yrs. last birthday) Yrs.	If Under 1 Ye Months Day		Ain. (Month, Da	th y, Year) 25,1939	9. Birthplace (State or Foreign Country) Washington, D(
	pu 🛦 ::		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	reation		•		
	Aaryla F sho	ō	MD Anne A							10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	the N 28e-1	Director	10e. Street and Number	under	Odent	10f. Zip Code			10g. Citizen of WI	
	3a or	Ö	2498 Amber Orcha	ard Court, F	E., #102	211			USA	iat oddiniy :
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Items 23a or 28e-f show avent. I've Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	r in U.S. 13.		of Hispanic Origin' uban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race	- American Indian, ; White, etc. White
Baltimore, Maryland 21215-0036	2 hou atura	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Bus	iness/Industry
215	hin 7:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during most of ired)	working		
21	filed wit Hygiene other the	Som	Listinostary, occorridary (o 12)	4	Civi	1 Serva	nt		NSA	
nd	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, T.E.M.	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)
yla	should be and Mental I s marked or umatic ava	ဥ	Theodore Post	La La casa de la casa				ces James		
Nar	2 sh and Ism raum		19a. Informant's Name/Relationship (7					Rural Route Numbe		
e,	s 1 and 2 should f Health and Men item 27 Is marke othar traumatic		Mary M. Post (Wi		2498	Amber	Orchard	Ct., E.,		enton, MD 21113
آور	ages 1 ar nt of Hea : If item		1 Burial 2XXX remation 3 D	tomoval mom otato	Ob. Place of Dispo cemetery, crei		1		20c. Location - C	City or Town, State
Ħ	permit. Pag Department Important: I any injury o		'4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Euler (Service License		Metro Cr			-2- 2004	Baltimo	ce, MD
Ba	permit. Pages Department of I Important: If ite any injury or of		Joseph C	1/1		Hardes 12 Rid	ty Funer	al HomeP.A	A. oolis. MI	21401
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying	a	nsequence of):		, ,			Approximate Interval Between Onset and Death
.O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical Exa	IF FEMALE:	Due to (or as a co	regnancy Fetal death 3	Ectopic pregnar	асу		23d. Date Month	
a	es tha igned be de	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause (given in Part I.	23e. Did to	2.6	oute to the cause of death?
Records,	The law ate has b page 2 si	Completed						24a. Was a autop	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2XNo
Vital	sician: certific irector,	Be	25. Was case referred to medical examiner?					Death (Check only or	10)	
of	Physician: this certific ral director,	ပို	1 1 1 42 5 7 10		2 ER/Outpatien	1 3 DOA		g Home 5 ☐ Resid		
on	ling After Tune	tlon	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. ate o Injury (Month, Day Yea	28b. Time of Injury	W	uryat 'ork? ⊒Yes 2 ⊒No	28d. Describe h	ow injury occurred	
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S)	At home, farm, stropecify)	eet, factory, office	9	28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funaral Dii completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	/ knowledge, death mination and/or inv	occurred at the restigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of Pertifier	The M	٥	29c. Lice	S J	F7 2	9d. Date signed (Month, Day, Year)
	20		30. Name and address of person who	impleted cause of death	V	PAnt)	A	I M	- 61 15	Center
ŀ	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 3 2004	32. Registrar's S	Signature				VILLE	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0035 nariorie 08 Kampley 04 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Battmore University of Maryland Medical Corte Battinove If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign
Country) 1 □ M 2 🗡 F Days Hours Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, it e Madical Examinat must be natified at 10d. Inside City Limits Director 1 Yes 2 No GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21060 ansbur USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIII o If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 ls marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES YOUNG ഉ MARIE BEATTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: if Item 27 Is eny injury or other treu once. JOHN RAMPLEY - HUSBAND 210 SANDSBURY AVENUE, GLEN BURNIE, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) GLEN HAVEN MEMORIAL 9/3/2004 GLEN BURNIE, MD 21. Signature of Funeral Service Line 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 FINK #M01148 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Iver failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): progressive diffuse B cell lymphoma **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Vo
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown ģ signed b d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed? (es 2 No certificate 1□ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e Dentaege MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Batimore ND 21201 lane DenHaese MD Greene St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar 111 Penn Street, Baltimore, Maryland 21201

ny

32. Resistrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

THE MOREM. 14-31. Date filed (Month SEP Per 3

			1 - For State Registrar	State of M	aryland / Depa			lental Hyg	_	-	28026		
	Physici		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		Year	3. Time of Death		
	/Media			France	s Estella I				1, 2004		10:00P M		
}	Examir	ıer	4a. Facility Name (If not institution, give				or Location of Death		4c. County o				
			2721 Moorgate Ro				indalk			ltim			
ſ.	Funeral Director		5. Social Security Number 6. Se 213-20-2905	х]м 2 ў Г	ge (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 23	Year) 3,1924		lace (State or Foreign try) 1and		
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits		
	d within 72 hours after death with the Maryland Jene. rithan "natural", or Itams 23a or 28a-f show the Medical Exterilier: and be ricified at	Director	2	imore		T	Du	ında1k			1 ☐ Yes 2X No		
	with the	Ö	10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	nat Coun	try?		
	s 23	rai	2721 Moorgate Roa		5	W - D - 1 - 11	21222		United				
	Itam	Funerai	11. Marital Status 1 ☐ Never Married — — Married	12. Was Decedent Armed Forces	Ever in U.S.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race Black	- Amenca , White, e			
21215-0036	Ir. or	by F	3 □ Widowed 4 □ Divorced	1 ☐ Yes 2√☐ If Yes, Give Year or Dates:	110	1 ☐ Yes 2 🛣 No	Specify:		Specify:	* *1			
Ö	2 hou	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bus		nite Hustry		
715	C	piet	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or	(Give	kind of work done DO NOT use retired	during most of work	ing			55,		
27	filed within Hygiene. other then	Completed	12 Years	College (1-40)		Homemaker	_		Otatr	1 Hom	ne		
B	be filed tal Hygi d othar event, t	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			162		
<u> a</u>	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve QDC8.	ToB	Daniel Peters				Th€	eresa Ke	ndrick		*		
Maryland			19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (Street	and Number or Rur			tate, Zip	Code)		
			Mr. John W. Rose	n / Husba	and 272	1 Moorgat	e Road I	Baltimore	e, Maryl	and	21222		
J.			20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of natory or other place			20c. Location - C				
Ĕ			1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)					004	Baltimo	re	Maruland		
Baltimore,			21. Signature of Funeral Studies Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.										
m			* Hordianu		VUYLUY.	Duda-Ruck	Funeral Ave. Du	Home of	Dundalk	, In	1C.		
			23a. Part1. Enter the disease, or compleshock or heart failure. List only o	ications that cause	d the death. Do not and	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate		
	Enysician .	edical resulting in death) a						Interval Between Onset and Death					
	/Medical		resulting in death)	a							ZWENTYCS		
4	Examiner			h =									
		Je.	Sequentially list conditions, if any landing to immuniate cause. Enter Underlying		a consequence of)								
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.										
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8760,	y s	cai		d									
9	death certifica e attending ph d for use as th	Med	IF FEMALE:			100							
Вох	death certific attending pl	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		Ectopic pregnancy	,		23d. Date		•		
-	ne dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		Other (specify)			Monti	n [Day Year		
P.0	that the de ed by the detached	Phy	9 Unknown										
	es De de	by	Part II. Other significant conditions co.	^	. 4		en in Part I.				a cause of death?		
ord	w requir been si should	ted	Territoneal	Caran	izotiema	\$		1 🗆 Ye	s 2∐no 3	☐ Proba	ably 4 □Unknown		
ecords,	e law r has be ge 2 sh	Completed						24a. Was an			sy findings available		
$\mathbf{\alpha}$	Th ate pag	mo.						perform	ed? de	ath?	2□ No		
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)				
of <	(S) (T)	2	1 Yes 2 No	Hospital: 1 ☐ Inpati		it 3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resider	nce 6 Other	(Specify)			
o u	ing After une	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Worl		28d. Describe ho	w injury occurred				
Sic	Attanding r death. sctor: After	cat	2 Accident investigation 3 Suicide 6 Could not be	20. 01	AAD TO A		Yes 2 □ No	201 1 1 10					
Division	after death after death Diractor: , d in by the f	Certification:	4 Homicide determined	28e. Place of In-	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str. City or Town,		or Rural.	Route Number,		
	Hospital		29a. Certifier 1 1 Certifying Phy	gieles: To the heet	of my knowledge, death	annumed at the time							
	e Hospital 24 hours a Funeral letely filled	edical	(Check only one)	ner: On the basis of and manner st	f examination and/or in	restigation, in my o	ne, date and place, a pinion, death occurr	and due to the car ed at the time, da	use(s) and mann te and place, an	ier as sta d due to t	ted. the cause(s)		
	To the Hospital or Attan within 24 hours after deat To tha Funeral Diractor: completely filled in by the	Me	29b. Signature and tytle of certifier	•		29c. License		29	d. Date signed (Month, D	ay, Year)		
	⊢s⊢ō			·	m.D.	3	45390	Se	epteurla	erl	, 2004		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO NIN (M.D.) 602 South Atwood Road # 200, Bel Air, MD 21014								,		
	6		MYO MIN (M.D.)	602 S	outh Ata	wood Rr	ad # 2	:00 Be	(Air.	MD	21014		
	Sta	te	31 Date filed (Month Day Year)	22 Pagiete	ar's Signatura	4 Som					•		
	Registr		SEP 03	2004	renewa &	1 Apra	les						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** cheverman. zabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson If Under 1 Year If Under 24 Hrs. BALTIMORE oilchrist (cnte 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) -32-9813 1 □ M 2 0 F Days Hours Yrs. Director north Carolin Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov other treumatic event, the Madical Examiner must be nutified at BALTIMORE Director 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 9021 21234 Be Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any injury or other treumatic event. If ite Midle 2006. Elementary/Secondary (0-12) College (1-4or 5+) Honemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whitson ဂ္ TRANK tranc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ichard i 20b. Place of Disposition (Name of cometery, crematory of other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill. 22. Name and Address of Facility 2325 YORK RD, TIMONIUM MD 20073 21. Signature of Funeral Service Licenses Victoria PEACEFUL ALTERNATIVES FUNERAL+CREMATION CTR 23a. Part I. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 0 rear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 XNo Other: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direc 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of centiler 29c. License number 29d. Date signed (Month, Day, Year) m 31,2008 address of person who completed cause of death (from 23a) (Type, Print) 6601 N. Charles Street GRMC 6701 Towson. Md. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 0 3 2004

8-06pm.

august 30, 2004

cheuerman, Betty

			1 - For State Registrar	State of Mary		artment of H <i>tificate of L</i>			iene	4 28028				
	Physici		Decedent's Name (First, Middle, Las Earl Way				-	2. Date of Deat Month	Day	3. Time of Death				
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		29 , 2004 4c. County o	T 0 T O T T 0				
			Harbor Hospital Ce			Baltimor				N/A				
	Funeral Director		227 00 1001	X 7. Age (In	yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 30,	^{Year)} 1952	9. Birthplace (State or Foreign Country) VA				
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits				
	n the Marylan r 28a-f show instiffed at	tor	MD N/A			Baltin	rore			¥¥Yes 2 □ No				
	골 ㅇ 웩	al Director	10e. Street and Number 3006 Huron Sta	æt		10f. Zip Code	21225	10	0g. Citizen of Wh	•				
36	hours after death w tural', or Items 23a	by Funeral	11. Marital Status 1 ☐ Never Married 2▼Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1	IS Army	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2√√No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White				
9	요 글 제		15. Decedent's Ed	Year or Dates: Vj	16a, Dece	ient's Usual Occupa	ution		16b. Kind of Bus					
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and 2	be filed stal Hyg od otha evant,	Be	17. Father's Name (First, Middle, Last) Farl W. Selph					ne (First, Middle, M	faiden Sumame,					
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 is marked othar traumatic ev	은	19a. Informant's Name/Relationship (Tharlotte J. Selph / V			g Address (Street a				tate, Zip Code)				
	Page: ment o ant: If ury or		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of				ity or Town, State				
aftimore,			1 ★ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify))	ilen Haven	-	Sept.	2, 2004	Glen Bu	mie Maryland				
Bal	permit. Depart Import any in		21. Signature of Europa Systytice Licens	** Victor P. I	wa, or ch	. Name and Addres a rle s L. St 01 Fast For	evens Fund	eral Home, Baltimore	Inc. MD 21230					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	sive Athe	er the mode of dying				Approximate Interval Between				
8760,	cate be executed obhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor										
P.O. Box 68	death certifi e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month					
	es op	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	nderlying cause give	n in Part I.		acco use contrib s 2 □ No 3	ute to the cause of death?				
Il Records,	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	ed? prid	ore autopsy findings available or to completion of cause of ath?				
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		th (Check only one						
of		. To	1 ☑ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury	at	ome 5 Resider						
ion	Attanding F r death. actor: After by the funera	atlor	XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	(r) Injury	Work	? es 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,					
Division	al or Atta after ded Diracto	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						eet and Number State)	or Rural Route Number,				
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical C	29a. Certifier 1 Cartifying Phy (Check only one) 2X Madical Exam	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the cau red at the time, dat	use(s) and mann te and place, and	er as stated. If due to the cause(s)				
)	To th withir To th comp	Me	29b. Signatur, and title of certifier A COLHA	llannd		29c. License			d. Date signed <i>(i</i> 1gust 29	Month, Day, Year) , 2004				
	2		30. Name and address of person who carol Allan, M.D.	ompleted cause of death	(Item 23a) (Type, I 111	Penn Str	cet, Bal	Ltimore, 1	Maryland	B 21201				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 3 2	32. Registrar's S	ignature	Sono								

			1- State of Maryl Registrer		artment rtificate			nd Me		giene	004	_28029	
	Physici	an	1. Decedent's Name (First, Middle, Last) MARY		SCHWA	DT7	MΛN		2. Date of Dea		วกนั _้ นู	3. Time of Déath 5:05 P M	
	/Medio Examir		4a. Facility Name (If not institution, give street and number)				Location of	Death	700031		County of De		
			JEWISH CONVALESCENT CENTER			CMIT					BALTI	MORE	
	Funeral Director			yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. 0 CT. 15			8. Date of Birtl (Month Day 0CT.15	1914	9. E	Birthplace (State or Foreign Country)		
	and		Usual Residence of Decedent 10a. State 10b. County 10c	:. City, Town or Lo	cation							10d. Inside City Limits	
	Maryl a-f sho	to	MD BALTIMORE	,,		IKES	VILLE					1 ☐ Yes 2 No	
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "netural", or items 23e or 28e-f show event, the Medical Exart and round be notified at	Funeral Director	10e. Street and Number		10f. Zip	Code	0100			10g. Citize	. Citizen of What Country?		
	death y	erai	1500 BEDFORD AVENUE #214 11. Marital Status 12. Was Decedent Ever	in U.S. 13.1	Was Deced	ent of Hi	21208		ify Yes or No- ican, etc.)	14	USA 14. Race - American Indian.		
36	or Ite	by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	lf Yes, spec 1 ☐ Yes 2		n, Mexican, Specify:	Puèrto R	ican, etc.)	ļ	Black, W		
9-9	2 hours	ted b	15. Decedent's Education	16a. Deced	dent's Usua	I Occupa	ition				d of Busine		
1215	within 7 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of won DO NOT us	k done a e retired,	lurina most o	of working				•	
d 2	filed v Hygie other t ent, th	e Co	17. Father's Name (First, Middle, Last)	PROPI	RIETOF	〈	18. Mother	's Name /	(First, Middle,			DRESS SHOP	
Maryland 21215-0036	ould be Mental arked o	To Be	MAX	LIEMAN			ANNA	4				KLASS	
Mar	t. Pages 1 arrtment of Heartent: If item 3		19a. Informant's Name/Relationship (Type, Print) KAREN SCHWARTZMAN / DAUGHTEF						Route Number			, Zip Code) ORE, MD 21210	
Baltimore,				Db. Place of Disposemetery, cren	sition (Nam	e of		Da				or Town, State	
Iţi m			'4 ☐ Donation 5 ☐ Other (Specify) M 21. Signature of Funeral Service Licensee	IKRO KODE								RE, MD	
 	permi Depa Impo any ir once.		Edward Chanal									., INC. , MD 21208	
				Approximate Interval Between Onset and Death									
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P.O.	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as I	Physician/Med	in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time 9 □ Unknown		Other (spe			-			Month	Day Year	
ري ح	es that tigned by	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying ca	use give	n in Part I,		23e. Did tol	bacco use	contribute	to the cause of death?	
ord	w require been sig should b	ted t							1 □ Ye	es 2 💢	No 3□!	Probably 4 Dunknown	
Rec	he law e has b	Completed							24a. Was a autops perforr	v	24b. Were a prior to death?	autopsy findings available completion of cause of	
ita		Be Co	25. Was case referred to medical examiner?				26. Place o	of Death (1 ☐ Yes 2 Check only on	ned? 2(X No e)	1 □ Ye	s 2 No	
o † <		္ရ	1 ☐ Yes 2 🂢 No Hospital: 1 ☐ Inpatient 2	2 ER/Outpatient			4 KY NUIS		5 Reside			ecify)	
lon	nding ath. r: After e funer	ation	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year	28b. Time of Injury	M 28	c. Injury Work 1 Y	at ? es 2 ∐ No		d. Describe ho	ow injury o	occurred		
Division of Vital Records,	al or Attanding P after death. I Diractor: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	office		28	f. Location (St. City or Town		Vumber or I	Rural Route Number,			
	spital		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred a	t the time	a. date and i	place, an	d due to the ca	ause(s) ar	nd manner a	is stated	
	To the Hospital or A within 24 hours after To tha Funeral Dirac completely filled in by	Medical	one) 2 Medical Examiner: On the basis of exam	nination and/or inv	estigation, i	n my opi	inion, death	occurred	at the time, da	ate and pl	ace, and du	le to the cause(s)	
	witi To	2	29b. Signature and title of certifier	\bigcirc	29c.	License	number 3757	17	2		_	nth, Day, Year)	
	V	1	30. Name and address of person who completed cause of death (i	Item 23a) (Type, F	Print)	V				34/	rew 10c	777004	
				avi St	Rei	ster	st~	M	15 d	134			
	Stat Registra		SEP 0 3 2004	10 A	poul	2/							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** David A. Sager September 2, 2004 3:55 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Stella Maris Hospice Baltimore Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 14, 1911 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 100 M 2□ F 92 yrs. 193-07-2197 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Iteme 23s or 28e-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No MD N/A Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6217 Everall Avenue 21206 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) General Electric al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist 12 SEPTEMBER 2, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) : 1 end 2 should be fi Health and Mental Hem 27 is marked ot Unknown Sager Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 a Department of Health ar Important: If item 27 is any injury or other trau Mr. Mark Lawlis/Grandson 9359 Highway 9, Breckenridge, CO 80424 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Sep 3 1 Burial 2 Scremation 3 Removal from State Chesapeake Crematory 2004 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M00986 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MELANOMA Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage of Injury) Due to (or as a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day signed by the all 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown should been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 Yes 1 Yes 2 No 2 **X**No director. Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

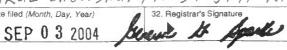
To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 2, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, M.D. 2300 Dulaney Valley Rd. Timonium, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 3 2004 Registrar

P.O. Box 68760.

Division of

			For 1 _ State	State of Maryland		ment of H			-	ette ette e	0000
			Registrar 1. Decedent's Name (First, Middle, Las	ct)	Certiii	cate of L	Jeani	2. Date of De	Reg. No	ZUU 4	2 8 0 3 J
	Physicia	an	· ·	Stockton				Month 09	Da		6:15 AM
	/Medic		4a. Facility Name (If not institution, give		4h	. City, Town, or	Location of D		40	. County of Dear	
	Examin	er	FOREST GLEN	NURSING		SILVEI			1,		TGOMERY
	Funeral Director		5. Social Security Number 6. S	Fex 7. Age (In yrs. Id	ast birthday) If	Under 1 Year onths Days	If Under 24		rth ay Year		thplace (State or Foreign puntry)
7			Usual Residence of Decedent	61							
9	how		10a. State 10b. County	10c. City	, Town or Location	on					10d. Inside City Limits
Mo	a -1 s	ctor	Maryland Prince G	eorges Be	ltsville	<u> </u>					1 ☐ Yes 2 📆 No
d div	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 21a or 21a-f show matic event, the Madical Examinet must be notified at	Funeral Directo	4511 Rom1on Stree	t	19	Of. Zip Code 20705			-	itizen of What Co ted Stat	,
000	dear	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was	Decedent of Hi	spanic Origin	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Ame Black, Whit	erican Indian,
	rs arter r, or Ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes Y No If Yes, Give Year or Dates:	1	Yes 2 No	Specify:	dono modn, stc.,		Specify: Whi	te
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	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last) Herbert Stockto				Mary	Name (First, Middle Sprows	e, Maidei	n Surname)	
	and la ma		19a. Informant's Name/Relationship (,		r Rural Route Numb			
2 7	Health Health Iem 27 other tr		Mrs. Margaret Dav					Hueytown	_		
ָּט ס	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other 20058.		20a. Method of Disposition 1 Burial 2 Fremation 3	Removal from State	ace of Disposition emetery, cremator	n (Name of ry or other place	e) 0.4	Date		ocation - City or	
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	Depart Depart Import any inj		21. Signature of Funeral Service Local	nsee				imothy S.			
	705 4 9		Sund not in	MCCMO111:				ve, Glen		nie, MD	
			23a. Part1. Enter the please, or com shock, or heart fillure. List only	plications that caused the death one cause on each line.	. Do not enter the	e mode of dying	g, such as car	diac or respiratory a	arrest,		Approximate Interval Between
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Registrar



			For State Registrar	State of Maryla		artment of F		fental Hygiei	and the second	20022
			Decedent's Name (First, Middle	le, Last)				2. Date of Death	* # * * * * * * * * * * * * * * * * * *	3. Time of Death
	Physici /Medio		Kalle Te	el				Month B	Day Year	1 15:15 M
	Examin		4a. Facility Name (If not institution	n, give street and number)		1 1	r Location of Death		4c. County of Dea	· 1
				ins Bayvieu		- Va.	Timore		Bultin	ore County
	Funeral		5. Social Security Number	6. Sex 7. Age (In yr	s. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	~	/5 113.			10-18-3	18 0	10111A
	land ow		10a. State 10b. County	/ 10c. (City, Town or L	ocation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary Hash	ţ	MN PAL	TIMORE	CAR	RASUS				1 ☐ Yes 2 No
	h the	irec	10e. Street and Number	Α		10f. Zip Code		10g.	Citizen of What C	ountry?
	23e c	Funeral Director	2908 ERI	E AVE.		2	1234		USI	7
	ems	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	or It	by Fu	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:),	hite
215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Medical Evertirer must be nutified at			Year or Dates:	16a Dece	edent's Usual Occup	nation	16h	. Kind of Business	Andustry
5	in 72 n "na redic	Completed	(Specify only highe	est grade completed)	(Give	kind of work done DO NOT use retire	during most of work	ing	, Allia of Dashiesa	· · · · · ·
212	filed with Hygiene. Ither ther	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Mec	hanice	el Engir	seer N	artinh	larietta
	e filed Il Hygi other vent, I	Bec	17. Father's Name (First, Middle,	1				e (First, Middle, Maio		,
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Maryland	2 should and Men Is marke eumetic		19a. I formant's Name/Relations			-		al Route Number, Cit	•	
-	1 and 1 Health 16m 27		Alice 1881	- Wite.	_ 290	8 ERIE	AVE, CH	POEY IN	000	34
Baltimore	Pages nent of ent: If it		20a. Method of Disposition 1 ■ Burial 2 □ Cremation		cemetery, cre	matory or other pla	CO)			
Ë	t. Pa tmen tent: ijury		'4 □Donation 5 □Other (5	Specify) CC	urrison	torest VH	Com. 18-30	1-04. Ca	rrison	, MQ
Bal	permit. Departr Importe any inji		21. Signature of Funeral Service	Licensee	2	2. Name and Addre	iss of Facility	HITMORE	, MOZ	1234.
			23a Part 1 Enter the disease	r complications that caused the de				IAPCL 880	DHHKI	Approximate
			shock, or heart failure. List	t only one cause on each line.				or respiratory arrest,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Ospirat	equence of):	ermina	-1			
В	Examiner					10 Sia				hours
		je	Sequentially list conditions, if any, leading to immediate	b. de to (or as a conse	equence of):	7				
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P.O.	uires that the de signed by the a Id be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	rueath 5	Other (specify)				
	that t ed by detac		Part II. Other significant conditi	ions contributing to death but not re	esulting in the I	underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute t	the cause of death?
ds,	uires sign ld be	d by	hypertension,	CVA, renal	insu f	ficiency,		1 🗹 Yes	2 No 3 P	robably 4 Unknown
00	w requir been si should	lete	Coronary art	ery disease, co		/	ctipheral	24a. Was an	24b. Were a	utopsy findings available
Records,	ding Physician: The lav h. Atter this certificate has funeral director, page 2	Completed		sease		1		autopsy performed	? death?	completion of cause of
ta	an: T	O	25. Was case referred to medica				26. Place of Deat	1 ☐ Yes 2 🗹	40 1 1 1 1 1 1 1 1 1 1	2 2 140
Division of Vital	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗆 Nursing Ho	me 5 Residence	6 □Other (Spe	cify)
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how in		
Sio	death. ctor: Al	atic	2 Accident invest	tigation		M 1 🗆	Yes 2 □No			
Ξ̈́	r Att ter de lirect	Certification:	3 Suicide 6 Could 4 Homicide determ	mined 28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (Street City or Town, St		ural Route Number,
	urs al									
	Hos 24 ho Fune	Medical	29a. Certifier 1 Certifyi (Check only 2 Medicel	ing Physician: To the best of my k I Examiner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred at the til rvestigation, in my o	me, date and place, ppinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Me	29b. Signature and title of certific			29c. Licens	se number	29d. I	Date signed (Mont	h. Day, Year)
	C)		1 Haron	Manhoh. M	D	03	4 125	8	125/	04
3	121		30. Name and address of person	nyho completed cause of death (It	em 23a) (Type				+	
_	10		Jason	Yanotski,	John	& Hapte	ins Ba	yvien H	ospital	
	Sta Regist		SEP 0 3 200	32. Registrar's Sig	Defure A	oouls				

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	Physici	an	Registrar 1. Decedent's Name (First, Midd LIA CLUENICION)			001	uncate	OI D	Calli		2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic Examin	al	WASHINGTON 4a. Facility Name (If not institution Sinai Hospita	n, give street and number)			4b. City, To				August	1	2004 County of Death N/A	1138 P ^M
	Funeral Director		5. Social Security Number 213 90 1267		e (In yrs. last b 28	oirthday) Yrs.	If Under 1 Months	rear	If Under 2 Hours	Min.	B. Date of Birt (Month, Day NOV • 9	, Year)	9. Birtl	nplace (State or Foreign untry) RYLAND
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD. N/		10c. City, To		cation MORE							10d. Inside City Limits 1
	death with the Maryland rms 23a or 28a-f show roust be rediffed at	Director	10e. Street and Number 4930 LANIER	AVENUE	1		10f. Zip Co	215				10g. Citizen of What Country? U.S. OF A.		
036	thin 72 hours after death with the Marylan e. an "natural", or Items 23a or 28a-f show Mudical Ezairisher must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? 1 ☐ Yes 2 I		1		t of Hisp Cuban,		gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - American Indian, Black, White, etc. BLACK Specify:	
1215-0036	within 72 ho ene. than "naturi he Medical I	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5	5+)	(Give	lent's Usual C kind of work of OO NOT use	done du retired)	ıring most	of working	orking 16b. Kind of Business/Ind			Industry
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e, Mar	. Pages 1 and 2 shot ment of Health and N tant: If itam 27 Ia mai jury or other traumai		PAULA TRICE 20a. Method of Disposition 1 □ Burial 2 ♣ cremation 4 □ Donation 5 □ Other ((MOTHER) 3 □Removal from State	20b. Place	930 of Dispo	g Address (S LANI sition (Name REMAT	ER of	AVEI		BALT	MOF 20c. Lo	cation - City or	YLAND 2121
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Suneral Service	I Dive	GWYNN	4	517 P	ARK	HE	IGHT	S AVE	NUE		215-6393 D.,MD.
	Physician /Medical Examiner		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	3V	of the death. Do	Ulnu						rest,		Approximate Interval Between Onset and Death
1760,	ite be executed iysician and ne burial-transit	icai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a consequence of):							1		
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Division of Vital	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medic examiner? 1 🎇 Yes 2 □ No	Hospital:			t 3 DOA	Other	r. 4□Nu	rsing Hom		ience (o ⊟Other (Spec	city)
ion	ding After fune	ation:	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	ing 28a. Date of Inju		Time of Injury	Рм 280	: Injury : Work? 1 🗌 Y			Sich lect			
Divis	or At ifter of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 289. Place of Iti	iury - At home, tc. (Specify)	farm, str	eet, factory, o	office			City or Tox	vn, State,	Number or Au Liberty Heg	Hall Route Number, Beltimore, MS. Me. MI)
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	To To com	Σ	29b. Signature and title of certif	outhail m					number M.E.				e signed <i>(Montl</i> rust 28,	
	3			outhail, mD	death (Item 23a			nn S	tree	t, Ba	ltimor		aryland	
	St Regist	ate rar	SEP 0 3 200	32. Registr	rar's Signature	4	books	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	State of Mai		rtificate of		Reg	ene 	28034	
Н	Physicia	an	1. Decedent's Name (First, Middle, Las Louis John UL					2. Date of Death Month	Day Year 2004	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death	6120	
			FRANKlin Squ	ARE HO.		Ros			BA171	MORE	
ı	Funeral Director		213 12 1122	7	(In yrs. last birthday 83 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	rear) 9. Birth Cou 1921 Mary	place (State or Foreign ntry) Land	
	and wc		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits		
	Maryl	tor	Maryland Baltimo	re		Baltimore				1 □Yes 2 No	
	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	eath w	eral	8100 Rossville	·	ver in U.S. 13		21236	ecify Yes or No-	U.S.A.	can Indian	
920	be filed within 72 hours after death with the Maryland Ital Hygiene. Id othar than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be multified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:)	If Yes, specify Cubin	lispanic Origin? (Sp. an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,		
2-0	72 ho "natur	eted	15. Decedent's Ed (Specify only highest grad		16a. Dece (Give	edent's Usual Occup e kind of work done	ation during most of work d)	ing	6b. Kind of Business/Ir	dustry	
121	e filed within al Hygiene. other then ' vent, ine Me	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+	-)	echanic	3)		Automobile		
d 2	be filed ital Hygie of other event, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M.	aiden Sumame)		
ylaı	2 should be and Mental is markad aumatic ev	10	John Valentine				Mary	Elizabe			
Maryland 21215-0036	t. Pages I and riment of Health riant: If itam 27 hiury or other tr		19a. Informant's Name/Relationship (7 Mr. Louis J. Ullr						City or Town, State, Zij • MD 21236	o Code)	
			20a. Method of Disposition	****		osition (Name of ematory or other pla			Oc. Location - City or T	own, State	
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Parkwood	l Cemeteri	1 9/4/2		saltimore,		
Balt	permit. Depart Import any in		21. Signature of Funeral Service Licen	500				_	uneral Hom MD 21236	es	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused to one cause on each line	the death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Respir	ATORY FA	AILURE					
ŀ	/Medical Examiner			COPD	EXAC	Rb ATIO	N				
		iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flar y, localing to monodate cause. Enter Underlying Cause (Disease or injury that initiated events A RESPIRATOR FAITURE Due to (or as a consequence of): Due to (or as a consequence of): Piet to (or as a consequence of): Piet to (or as a consequence of): Cause (Disease or injury that initiated events)								
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68760,	ate be hysicia the bur	edlcal	(đ.							
	certific iding p	/Mec	IF FEMALE:	23c. If yes, outcome o	of pregnancy				23d. Date of deliv	Prv	
.O. Box	that the death of the by the attended by the attended for u	hysiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnance □ Other (specify) _	/		23d. Date of delivery Month Day Year		
<u>Δ</u>	og ped	by P	Part II. Other significant conditions of Ashes Tosi's	ontributing to death but	t not resulting in the	underlying cause giv	ven in Part 1.	23e. Did toba	acco use contribute to t	he cause of death?	
Records,	The law requir ate has been si page 2 should	completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of	
Vital	Physician: The la this certificate ha ral director, page 2	BeC	25. Was case referred to medicat examiner?	Hospital:		O#	-	h (Check only one)		
of	ding Phys	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time	of 28c. Inju	v at	me 5 Resider 28d. Describe how	ice 6 Other (Speci v injury occurred	(y)	
Division	al or Attanding s after death. Il Director: After id in by the fune	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,	
	To tha Hospital or within 24 hours after To tha Funaral Director completely filled in b	Medical (examination and/or i				use(s) and manner as s e and place, and due t		
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Month,	**	
•	2		Your y	5			0000	09/12/04			
	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) Soliau =	he Roll	MADE	Md 2/23	7	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	ZUNKE	UKI WAIT	I III URE	27 00 0	1	
	Regist	rar	SEP 0 3 2004 Z	remenas	M Ara	1					

DHMH 17 Rev 1/2001

Louis

and Mental Hygiene

4-05607		For	State of Maryland / Department of Health
RJ	1-	For State Registrar	Certificate of Death

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Reg.	No.	U	U	L.	2	0	U	J	4

RJ	1	For State Registrar	,,,,	Ce	rtificate of	Death	,	Reg. No.	004	28035
		. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
Physiciar /Medica		FLOYD A VIN	IES				August	30,	2004	12:03 A.M
Examine		a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, o	r Location of Death		4c. Co	ounty of Death	
•		Franklin Square Hos	spital	for Addish do	BALTIM If Under 1 Year		O Data of Dia	Bal	timore,	County
Funeral		6. Sex 1218-17-9251	M 2□F	i. last birthday) 16 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Date NOV . 20	y, rear	Cour	nace (State or Foreign htry) YLAND
Director	_	Jsual Residence of Decedent		10			140 0 . 20	, 1507	PIPAL	LIBAND
yland	1	Oa. State 10b. County	10c. C	ity, Town or L	ocation				1	0d. Inside City Limits
e Mar		MARYLAND N/A		BALTIM	ORE					1 X Yes 2 No
with the Marion 28e-1s	1	0e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cour	ntry?
death with the Maryland ms 23a or 28e-f show troat be neithed at		616 N BELNORD AVEN	IUE 2. Was Decedent Ever in I	11.6	21205			S.A. Race - Americ	an Indian	
of the death of the feet of th	1	1. Marital Status 1 XXNever Married 2 Married 1	Armed Forces?	0.5.	If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	- 14.	Black, White,	
JSO JIS att	D Y	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2DNo	Specify:		Sp	pecify: BLA	CK
be filed within 72 hours after death with the Marylan la! Hygiene. d other then "naturel", or tlems 23a or 28e-f show event, the Medical Everni et mast be notified at	ם ב	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of work	16b. Kind	of Business/In	dustry	
thin 7	2	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	9			
filled will Hygien ent, the	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) STUDENT						8. Mother's Name (First, Middle, Maiden			
Viana Z ould be filed v Mental Hygie serked other hatic event, th	ă	7. Father's Name (First, Middle, Last)	IDON.					imame)		
aryia should nd Men marke umatic	2	CHARLES HENRY BROG		19h Maili	ing Address (Street	LORINE I			own State Zin	(Code)
re r		Lorine Vines/Mother				Dr., Ess		-		
Hear Hear of the sther	_	20a. Method of Disposition		Place of Disp	osition (Name of omatory or other plan	3-1	Date Date		tion - Cîty or To	own, State
Pages nent of net: If it	ì	1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)		•	F FAITH M		7-04	ват.тт	MORE - I	MARYLAND
Baltimore, permit. Pages 1 ar Department of Hea Importent: if item eny injury or othe		21. Signature of Funeral Service License		2	2. Name and Addre	ss of Facility	*			
z geeg		parlown 1	1	1	206 W NOF	BROWN CON	₹		CAL HOM	E P.A.
		23a Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician	100	Immediate Cause (Final disease or condition	nunshat	wes	and of					Onset and Death
/Medical Examiner		resulting in death)	Die to (or as a conse	equence of):		0				
		Sequentially list conditions, b	Due to (or as a conse	anonce of):		0				
executed n and ial-transit		Sequentially list conditions, if any, leading to immediate caucage. Cause (Disease or injury	Due to (or as a conse	querice or,						
icate be executed physician and sthe burial-transit	Xal	that initiated events cresulting in death) Last	Due to (or as a conse	o (or as a consequence of):						
68/6U										
os 68 /60, certilicate be executed ding physician and use as the burial-transit	Medical									
Box 68 leath certilics attending pt	_	23b. was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnanc	v		230	d. Date of delive	
. 0 00	SICI	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of 9☐ Unknown		Other (specify)	•			Month	Day Year
requires that the deseen signed by the a	Physician	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not re	sculting in the	inderlying cause an	en in Part I	23a. Did t	obacco usa	contribute to the	ne cause of death?
ires the signer	2	Part II. Other significant contamons con	insuling to assure our not re	southing in the	andonying cause go	TOTT HET GIVES	1 🗆 '	- 1		
w require been signatured should be	erec						24a. Was	- 1		ney findings available
4) a a c	Completed						autor		prior to co death?	psy findings available mpletion of cause of
Vital I		25. Was case referred to medical				26. Place of Deat	h (Check only o	2 No	Yes	2 No
Of Vita Physicien: this certific ral director,	٥	examiner?	ospital: 1 Inpatient 2	X ER/Outpatie	nt 3 DOA Ott	ner:	ome 5 Resid		Other (Specif	y)
Division of to Attending Phy after death. Director: Atter this in by the funeral d	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe			-
Attending or death. ector: Atterby the fune	310	1 Natural 5 Pending 2 Accident investigation	8-29-04	10.5		Yes 2 No	Sup	ject	2110	
Divis	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Rural Route Number or							1 /-	
Ditel o		, <u> </u>		24	reet		£3584	1356	>	7 (700.2)
Division of Vital Re To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: Atter this certilicate in completely filled in by the funeral director, page	edical		sician: To the best of my kiner: On the basis of examinate and manner stated.							
o the ithin (o the omple		29b. Signature and title of pertifier	Commenter decision		29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)
F \$ F 0		2	KOO2	us_	OCI	Œ		Αυ	igust 30	0, 2004

State

Registrar

31. Date filed (Month, Day, Year)
SEP 0 3 2004

32. Registrar's Signature

(A - 10 | AK MD 111 Penn Street, Baltimore, Maryland 21201 30 Name and address of person who completed oarse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10:18P **Physician** Wade 2064 /Medical 4a. Fecility Name (If not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death **Examiner** (Enter 1ch rist 250r lou TIMORU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 € F Months Days Hours Min. 219-30-2775 43 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at Director PARKVILLE 1 ☐ Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23a 21234 Hone Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) Cotlege (1-4or 5+) Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ larence TRANKLIN slade Hnna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun Madonna daughter MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of pisposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State V. cromatory or other place)

BEL AIR

FUNERAL GHARTI 9-3-04 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FOREST HILL, MD 21050 Kindler EVANS FUNCTAL CHAPEL-BELAIR, 3 NEW PORT DR complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate
Interval Between
Onset and Death
MCNHCS 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) pulmonale **Physician** /Medical Due to (or as a consequence of): Examiner emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 2 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) 1 🗆 Yes should be detached 9 Unknowi Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vulor heart dispase 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Dother (Specific Specific Spec 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. М al or Attendi s after death. investigation filled in by the 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check on one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 8303 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
SEP 0 3 2004

32. Registrar's Signature

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EPTEMBER 1,

owson, no

	04-0558		stopher Weston Please Type or Print in Black In State of Maryland / Den	-	•
	RPD Physici	an	State of Maryland / Dep. State of Maryland / Dep. State of Maryland / Dep. Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	of Death 3. Time of Death
>	/Medic Examin	al	4a. Facility Name (If not institution, dive street and number) 3488 Spelman Road	4b. City, Town, or Location of Death Baltimore	ust 28, 2004 0800 P M 4c. County of Death
2	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8, Date of	of Birth 9. Birthplace (State or Foreign 1. pay (State or Foreign
) ==	Maryland -f show	tor	Usual Residence of Décedent 10a. State 10b. County 10c. City, Town or L NTO NA DALC	ocation TIMORF	10d. Inside City Limits 1 Pes 2 No
	with the 3a or 28e	Funeral Director	10e. Street and Number 3HBh SOF MAN R9	10f. Zip Code 2125	10g. Citizen of What Country?
036	urs after death with the Marylar el', or liems 23a or 28e-f show Examiner (ust be mulfiled at	by	11. Marital Status 1	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 ☐ No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: Plack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If them 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examination to be notified at an once.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) AR WASAER	16b. Kind of Business/Industry CAR WASH
Maryland	should be file ind Mental Hy marked othe umatic event	To Be (17. Father's Name (First, Middle, Last) NATIBULE WESTON	18. Mother's Name (First, M	MOVFIELD
	l and 2 sho lealth and om 27 is m her troum		DOROTHY WESTON 4019	ing Address (Street and Number or Rufal Route N W H Roy R Osition (Name of Date	umbel, City or Town, State, Zip Code) DAT, M.D., 1227 20c. Location - City or Town, State
altimore.	it. Pages ritment of H		1 ☐ Burial 2 ☐ Germation 3 ☐ Removal from State completely. Cre 1 ☐ Donation 5 ☐ Other (Specify)	matery or other place) 9-2-04 12. Name/aboutpass of Facility 2/14 + 111	ANDIN'S MP,
Ba	permit. Depart Import any inj		23a. Part Lever the Mease, or complications that caused the death. Do not en	270 FREDHILDEN BASS E	PALT MD, HILL Approximate Approximate
>	Physician /Medical		shock, if he in failure. List only one cause on each line. Immediate haves (Final disease or condition resulting in death) Arcotic and Coc as a condition		Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):		
.09	be executed sician and burial-transit	ai Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
P.O. Box 68760	ndir use	by Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	e law requires that the death has been signed by the atte		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Becords.	The law req ate has beer page 2 shou	Completed			Was an autopsy findings available prior to completion of cause of death? ✓es 2 □ No
of Vita	hysicien: his certific	To Be	25. Was case referred to medical examiner? 1		Residence 6 MOther (Specify) At Scene
sion o	tending Peath. or: After the funera	Certification;	27. Manner of Death 1	P M 1 □ Yes 2 X No Uni	cribe how injury occurred
Ö	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certif	4 Homicide determined Found at home	Balti	ion (Street and Number of Rural Route Number of Town, State) 3488 Spelman Rd.
	the Hosp thin 24 ho the Fune mpletely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, dea 2 Medical Examiner: On the basts of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
•	T with		29b. Signature and title of certifier The Shall My	O.C.M.E.	August 29,2004
	Loba.		30. Name and address of person who completed cause of death (Item 23a) (Type 4 COR 5 C. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Balti	more, Maryland 21201
	St Regist		SEP 0 3 2004	whi .	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Weeks Emma Ruth A^{M} August 30, 2004 8:20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Co. Dundalk Genesis Heritage Meridian Ctr. 8 Date of Birth (Month, Day, Year) July 18,1921 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2√2 F Months Days Hours 83 Yrs. Director 213-14-2411 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic evant, the Modital Experient roughter matter at 1 ☐ Yes 2√ No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 101 Center Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 XNo Specify: Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Years Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is markad oth eny linty or other traumatic evant 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Urlich 10 James Baroch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 407 Sylview Drive Pasadena, Maryland Ronald Weeks / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2-☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/2/2004 1 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Ent The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events The attending physician and resulting in death) Last Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year jo Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy certificate 2 No 1 Yes or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 4 Ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 1 Natural completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

			1 - State Registrar	State of Ma	ryland		rtmen tificate			and M	_	giene Reg. No.	001	-}	28(39	3
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary Ellen Whitt					-			2. Date of De Month August	ath Day	3004	eer	3. Time	of Deat	h
	/Medic Examir		4a. Facility Name (If not institution, give st Mariner Health of				4b. City,		Location of		August	4c. County of Death Harford			, A		
	Funeral Director		0/9-26-3562	M 2 F 7. Age	(In yrs. las	t birthday) 9 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Dec 2,	th y, Year) 1934	9 1	Birthpl Coun New	lace (Stat try) York	e or For	ign
	Marylend Ited at	tor	Usual Residence of Decedent		10c. City, Bel	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No		/		
	with the	Direc	10e. Street and Number				10f. Zip						p. Citizen of What Country?				
036	urs after death us al', or items 23.	by Funeral Director	410 E. McPhail Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	/	11	Vas Deced	ent of His	spanic Ori n, Mexican Specify:	gin? (Spe	ocify Yes or No Rican, etc.)	- 1	4. Race -	America White, e	an Indian, etc.		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exercitiest and be incillised at or other traumatic event, the Medical Exercitiest and be incillised at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation completed) College (1-4or 5-	+)	16a. Deced (Give life. L Homem	kind of wor OO NOT us	l Occupa k done d e retired)	tion uring mos	t of workii	ng	16b. Kin	16b. Kind of Business/Industry Dwn Home				
yland		To Be C	17. Father's Name (First, Middle, Last) Michael F. Murphy-						Elle	n Le	ee		faiden Sumame)				
Mar	nd 2 sh lith and 27 is m r troum		19a. Informant's Name/Relationship (Typ Mary Ann Mershon/D								de Gra						
altimore,	permit. Pages 1 and 2 Deportment of Health a Importent: if Item 27 is any Injury or other tree		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	сел	ce of Dispos netery, crem sapeal	sition (Nam natory or of	e of ther place	9)	S	ep 1 004	20c. Loc	ation - Cit	y or Tov	wn, State		
Balti	permit. Depertre Importe any Inju		21. Signature of Funeral ServicerLicensed	"U nu	30%	0 22	Name and	d Address	s of Facilit	Fune ture	ral Alt s Drive		tives		MD		
8760,	The law requires that the death certificate be executed we have been signed by the attending physicien end up is larged as from the burial transit or use as the burial transit.	dicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a	consequer	nce of):	Chri	onic	41	1.	tive	Puli	non ease		Approxim Interval B Onset an	etween	-
O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal de	eath 3 🗌	Ectopic pre Other (spe		,			23	3d. Date of Month		ry Day	Year	
rds, P.	w requires that the been signed by should be deta		Part II. Other significant conditions cont	ibuting to death but	t not resulti	ng in the un	derlying ca	use give	n in Part I.		23e. Did to	/			a cause of		٧n
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Division of	To the Hospitel or Attending Physicien: To thin 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director,	-	27. Manner of Death 1 \$ Patural 2 Accident investigation	28a. Date of Injury (Month, Day	28	VOutpatient Bb. Time of Injury		Bc. Injury Work			ne 5 Resid 8d. Describe h			Specify)			_
Divis	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	(Specify)						8f. Location (S City or Tow	m, State)				mber.	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examine	cian: To the best of ir: On the basis of e and manner state	examination	edge, death n and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, deat	d place, a h occurre	nd due to the o d at the time, o	ause(s) a date and p	ind manne place, and	r as sta due to t	ted. the cause	(s)	
	To th To th comp	Me	29b. Signature and title of certifier)	0		29c.	License	number			29d. Date	signed (M	lonth, D	ay, Year)		_
	M		30. Name and address of person who com	pleted cause of dea	ath (Item 2:	3a) (Type. F	Print) 4	41	958	3	L F	tug	45	3	1,5	200	4
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signatur	9 4	port	23					- • •	_	,	ı	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kentwarn Watkins 04-05501 State of Maryland / Department of Health and Mental Hygiene For State Registrar **RPD** Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) 3. Time of Death Month Dav Year **Physician** KENTWARN Q. WATKINS 26. 0113 A August. 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University of Maryland Hospital Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F Months 24 Director 7, 1980 MARYLAND 220-94-2509 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f ehow treumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 4237 SEIDEL AVENUE 21206 U.S.A. or Items 23a Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Items 23: Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐ Yes 2 **⊠ M**o If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A UNEMPLOYED 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VAUZELLA JONES BEN WATKINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4237 Seidel Ave., Baltimore, Maryland 21217 Vauzella Jones/Mother other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Importent: If eny injury or one one 08-31-04 LANDSDOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 21. Signature of Fungral Service Licensee arbain 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mushot Multiple Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: nse. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 🗌 Yes 2X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed Yes 2 No Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ XXYes 2 No this A 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending s after dec. Subject 126/04 She 12:19 1 Yes 2 No investigation М 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Starrevey area MXHo determined 4 Homicide chapster 300 block Vine Street, Baltimore, Fil 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number Zalmillah O.C.M.E. August 26, 2004 3

State Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BILLE

31. Date filed (Month, Day, Year)

SEP 0 3 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician SEPTEMBER 2,2004 Frederick Edwin Winter 4:30A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Dec. 01, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral X**□M 2□F 113-09-8489 Yrs 84 Ĩ919 New Jersey Director Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c, City, Town or Location 10d, Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Md. Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "nature." ---- eny injury or other traumatic event 7101 Sheffield Rd. 21212 USA Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) +4 Elementary/Secondary (0-12) Systems Analyst Financial 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frederick Joseph Winter Florence Volskmain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois Winter/ Wife 7101 Sheffield Rd. Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 9-4-04 Timonium, Md. 21. Signature of Fundal Service Licenses ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RIGHT LUNG ABSCESS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a detached 9☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 be 2 No 3 Probably 4 Unknown 1 □ Yes page 2 should METASTATIC COLON CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a. Was an certificate has autopsy 1 Yes 2 No Vital Physicien: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 28b. Time of Certification: Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I within 2 To the 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year) September 2,04 0017695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDAL AH HELDU M.
31. Date filed (Month, Day, Year) 7601 OSLER DRIVE TOWSON MARYLAND 21204 32 Registrar's Signature State SEP 0 3 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

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E	S		1. Decedent's Name (First, Middle, Last)				2. Dete of Dee Month		Year .	3. Time of Death
	Physicia /Medica		Amelia Laura Albright			. O: T	Septem		2004	7:55pm
	Examine	r	4a Facility Neme (If not institution, give street and number) Westminster Nursing & Rehabil	.itati	ve Center		ster	4c. County of Carrol		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 218-03-6810 91 Usual Residence of Decedent	lest birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 1 1	, Year)	9. Birthp Court Md	lace (State or Foreign ltry)
	hand hand	.	10a. State 10b. County 10c. City	y, Town or Lo					1	0d. Inside City Limits
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	ath with the Marylar 23a or 28e-f show	ai Director	10e. Street end Number 1509 Woodbridge Lane		10f. Zip Code 21784			USA	hat Cour	ntry?
20	r hems	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give ☐ Yes		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- Americ k, White, whit	
<u>ö</u>	hours fural',	ed by	3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Dece	dent's Usual Occup	etion		16b. Kind of Bus		
21215-0020	within ane.	Completed	(Specify only highest grade completed) Elementery/Secondary (0-12) 12 College (1-4or 5+)		kind of work done DO NOT use retired omemaker	during most of work d)	ing	domest	cic	
land 2	T d of H	o Be C	17. Father's Neme (First, Middle, Last) William McHenry			18. Mother's Nam Emma Wir		Maiden Sumame	a)	
Mary	id 2 shorth and N		19a. Informant's Name/Relationship (Type, Print) Keith Albright (son)		ng Address (Street Woodbrid					
Baltimore, Maryland	permit. Pages 1 an Department of Haal Important: if Item 2 any Injury or other once.		4 Millioniat 2 Comption 2 Demonstrate C	emetery, cre odlawn	osition (Name of matory or other plac Cemetery	Ç		20c. Location - 0 Baltimon	re, N	1d
Balt	permit. Pa Departmen important: any injury phos.		21. Signature of Funeral Service Licensee Page Haight Herbert	2: P	2. Name and Addre	^{ss of Facility} Hai 95 Sykesv	ght Fun ville, M	eral Hon d 21784	ne &	Chape1
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	1	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a. Carebourg	fint	}		1			
	-	ner	Immediate Cause (Final disease or condition resulting in death) a. Carebourge Due to (or condition to the condition of the	as a conse	quence of): Tip Sel	eratu Va	iscular	Disen	ne	25yr
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of Vital Records,	w requires been sign should b	Completed t					24a. Was a perfor	an eutopsy med?	av	ere autopsy findings ailable prior to mpletion of cause death?
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<u>></u>	hysic this ca al dire	2	1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie		4 Nursing ric		ence 6 □Othe		y)
	tending Ph leath. tor: After th tha funarai	Ö	27. Menner of Death 1 ★ Naturel 5 Pending (Month, Dey Year)	28b. Time o Injury	Wor	yet k? Yes 2⊡No	28d. Describe n	ow injury occurre	30	
Division	or Attending Physician: after death. Director: After this cartific. in by tha funaral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st			28f. Location (S City or Tow	treet and Numbe n, State)	or Rura	al Route Number,
	Hospi 4 hou Funer taly fil	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, deat tion end/or ir	th occurred at the tire	me, date and place, pinion, death occur	and due to the o	ause(s) and mar late and place, a	ner as s nd due to	tated. o the cause(s)
	To the Within 2 To the comple	Me	29b. Signature end title of certifier		29c. Licens	e number	1	29d. Date signed	(Month,	Day, Yeer)
			I John W Middleton		D2	5443		9/3/2	00 5	/
	1	n	30. Name and address of person who completed cause of death (Item		, Print)	1, West	1 .	(1	7	21157
	Stat	y.	31. Dete filed (Month) Proposition 7 7 1114 32. Brangers Signa	1 ool	And 0	ופניען,	mnast	er, vv	$\cup \mathcal{D}$	40/
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DHMH 17 Rev 1/2001

Registrar

2004

David	Albright	Sr.
04-056		
MAN		For

David Bruce Albright David Bruce Albright Sale David Bruce	015
## Figure 1 As Facility Name (if not institution, give street and number) As City, Town, or Location of Death Ast. County of Death	ime of Death
S. Social Security Number 6. Sex 217-50-7561 12M 21F 7. Age (in yrs. last birthough) 10 10 10 10 10 10 10 1	.US_A
10. Sistate 10. County Baltimore 10. City, Town or Location 10. City Baltimore 10. City Baltimore 10. City Baltimore 10. City Code 10. City City Code 10. City	State or Foreig
ETHEST Jurgan Albright The Ima M. Filiatrault The Ima M. Filiatrault The Ima M. Filiatrault The Ima M. Filiatrault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Joseph Albright/son 2737 Norland Road, Baltimore, Maryland 2123 20b. Place of Disposition (Nume of cemtelen), crematory or other place) 20b. Place of Disposition (Nume of cemtelen), crematory or other place) 21. Signatule of Filiatrault 22. Signatule of Filiatrault 23. Signatule of Filiatrault 24. Decation - City or Town, State, Zip Code) Sept. 5 Chesapeake Creamtion 2004 Stevensville, 22. Name and Address of Facility Singleton Funeral Home P 1 Second Avenue S.W., Glen Burnie, MD 210 25. Due to (or as a consequence of): 26. Due to (or as a consequence of): 27. Due to (or as a consequence of): 28. Signatule of Filiatrault 29. Was decedent pregnant in the past 12 months? 1 yes 2 No 3 probably 29. Unknown 29. Unknown 29. Unknown 20. Unknown 21. Other (specify) 22. No 3 probably 24. Was an an always performed of performe	side City Limit □Yes 2 🔀 N
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ETHEST JURGAN AIDFIGHT The Ima M. Filiatrault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Joseph Albright/son 2737 Norland Road, Baltimore, Maryland 2123 20b. Place of Disposition (Name of cemeter) 20c. Location - City or Town, State, Zip Code) 20c.	
3a. P. ft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Sa. P. ft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate Cause (Final displayed or conditions or drifting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Appropriate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate App	0
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Selin be a proper to the prope	Year
May res 2 I No 1 May res 2 I No 1 May res 2 I No 1	se of death?
	on of cause of
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred work? 28. Describe how injury	Cichara e Number
29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the time, date and place, and the cause(s) and manner as stated.	ause(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y) O.C.M.E. August 31, 200	
30. Name and address of person who completed cause debath (Item 23a) (Type, Print) THEODIFE M. (Given 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120: State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

			For State Registrar		State of Marylar		artment of H			giene Reg. No.	Total Control	2801.6
	Physici /Medic		1. Decedent's N	AM Pame (First, Middle, Last	DNE.				2. Date of Dea	Day	2004	3. Time of Death
	Examin Funeral Director	er	2/19	ity Number 5. Se	AVE.	. last birthday) Yrs.	4b. City, Town, of	or Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da		9. Birthe	2 place (State or Foreign trop) INDIE
	Maryland f show	jo	Usual Resident 10a. State	ce of Decedent 10b. County	A 10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the I 23a or 28a-	Funeral Director	10e. Street and	Number SEDATEN	AVE	171,27	10f. Zip Code	30		10g. Citiz	en of What Cour	ntry?
036	urs after deat al', or Items ? Examina fron	by		tus Married 2 Married red 4 Divorced	12. Was Decedent Ever in to Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		4. Race - Americ Black, White, Specify: **PIII	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mydical Exam in the mittle and once.	Completed		15. Decedent's Edi Specify only highest grad Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of world	king	16b. Kin	d of Business/In	DOYED
Maryland	ould be filed Mental Hygi arked othar atic evant, I	To Be C	17. Father's Na	ame (First, Middle, Last)				18. Mother's Nam	A ED	WAT	209	
	1 and 2 sho Health and som 27 is mather traums		DEGD	t's Name/Relationship (7	11617	212	ng Address (Street	and Number or Ru	ral Route Numbe	RE.	Town, State, Zip	4223
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		`4 □Donat	2 Gremation 3 L tion 5 Other (Specify	Removal from State	Cometery, cres	natory or other pla	се)	8-04	CARO	シックル	M
Ba	permit. Departr Imports any inje			of Edineral Service Ucen	state and the deal state of th		270 Fre	DHILTON	TASS T	INII	MD. 2	App oximate
	Physician /Medical		shock of Immediate a disease or cor resulting in de	r Feart failure. List only ou suse (Final ndition	a	My	CARD	1AL 1			rion	Interval Between Onset and Death
	Examiner	iner	Sequentially li if any, leading cause. Enter Cause (Diseas	ist conditions, to immediate Underlying	b. Due to (or as a conse	YPER	TEN	0/612				
8760,	icate be executed physician and s the burial-transit	cal Examiner	that initiated e resulting in de	Vents	c. Due to (or as a conse	quence of):	41)					
.O. Box 68	ne death certif the attending thed for use a	Physician/Medl	in the pa	st 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc	у		2	3d. Date of delive	ery Day Year
Ф	es lgn be	by	Part II. Other s	significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to		se contribute to the	ne cause of death?
Vital Records,	The ate he page	Completed									24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
of Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case examiner? 1 Tyes	referred to medical 25 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier		26. Place of Dea her: 4 ☐ Nursing H			□Other (Specif	(y)
ion o	Attanding PI r death. actor: After th by the funeral		27. Manner of 1 Natura 2 Accide	al 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at rk?] Yes 2 □ No	28d. Describe h	now injury	occurred	
Division	in the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)								Number or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in I	edical	29a. Certifier (Check on one)		ysician: To the best of my kr niner: On the basis of examin and manner stated.							
)	To th within To th comp	Me	29b. Signature	e and title of certifier	Sugh 1	4.0	29c. Licen	0			signed (Month,	
•	8	-	30. Name and	address of person who	0000		Print) APOL(s ROB	D P	ACT	to MO	21230
	St Regist	ate rar		(Month, Day, Year)	32. Registrar's Sign		pach				- ' ''	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mae WU /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 20 Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 337-44-9655 Usual Residence of Decedent 1 M 2 F Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other treumatic event, the Medical Exact per must be notified at Be Completed by Funeral Director WP 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Items 23e Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married ō 1 □ Yes 2 B No 3 Widowed 4 Divorced Specify BIACK permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "naturel". any injury or other treumatic event, the Medical Exa ance. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-40)5+) Nann 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number ruenello Baltimore, 20a Method of Disposition 1 Surial 2 Cremation 3 Pemoval from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name Address of Facility Greene Funeral STIC Kamalbtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, p Mellitus 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 1 🗌 Inpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of Director: After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

2401 W. Belvedere

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2004

MD

Hansen

31. Date filed (Month, Day,

D59062

Baltimore

September 1, 2004

MD 21215

Patient known as Ann Bridges

			Please	State of Manuar					gible.	
			1 - For State Registrar	State of Marylan		tment of Health and ficate of Death	Mental Hy	20	nI.	2001.0
			Decedent's Name (First, Middle, La	ast)			2. Date of D		he	3. Time of Death
	Physici /Medi		Ann Marie	Bridges			August	Day 31	2004	1122 AM
	Exami	ner	4a. Facility Name (If not institution, gi	1 0 -		b. City, Town, or Location of Dea	th	4c. Cou	nty of Death	11/4
2	Funeral			Sex 7. Age (In yrs.	last birthday)	Battimore Cit	8. Date of B	rth	9. Birth	place (State or Horeign
3	Director		J11-00-9200	10 M 20 F 62	Yrs.	Months Days Hours Min	12-6	ay, Ygar)	Cou	ntry) M
, –	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loca	ion _				10d. Inside City Limits
	ith the Marylar or 28a-f show	ctor	mp Bal	timore		Reisterstown	1			1 □ Yes 2 No
	vith the	Director	10e. Street and Number	1 01		10f. Zip Code		10g. Citizen	of What Cou	ntry?
	within 72 hours atter death with the Maryland ene. han "netural", or Items 23e or 28a-f show ha Medical Exant ar must be a diffed at	Funeral	11, Marital Status	12. Was Decedent Ever in U.	S. 13 Wa	S Decedent of Hispanic Origin? (Specify Vec or N	0s 14 B	ace - Americ	can Indian
9	atter c		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		s Decedent of Hispanic Origin? (ses, specify Cuban, Mexican, Puer	to Rican, etc.)		lack, White,	
. 00	hours ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:	1	Yes 2 No Specify:		Spe	Sify: 6	ACK
215-0036	nin 72 n "net	Completed by	15. Decedent's E (Specify only highest gr	ade completed)	(Give kin	t's Usual Occupation d of work done during most of wo NOT use retired)	rking	16b. Kind of	Business/In	dustry
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Maryland	2 should be tiled with and Mental Hygiene. is marked other thar aumatic event, the M	Be	17. Father's Name (First, Middle, Las.	hana		18. Mother's Na	me (First, Middle	, Maiden Sum	ame)	
<u> </u>	should and Men marke	ြင	19a, Informant's Name/Relationship	(Type, Print)	19b Mailing	Address (Street and Number or R	ural Boute Numb	onith	m State Zir	Code
_			William B. Bri	dges TIL (Son)	2616	McKenzie Ro	Ella	HC1	mr	21142
altimore.	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition		lace of Dispositi emetery, cremat	on (Name of ory or other place)	Date	20c. Locati	n - City or To	own, State
II.	nit. Page artment ortant: It injury o		* 4 □ Donation 5 □ Other (Speci	(y) Ga	urison	Forest 97	7-04	Owin	as n	ills, MD
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee I	\$7	ame and Address of Facility	mann C	Green	of Fu	noral Sruc
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the death	n. Do not enter	he mode of dying, such as cardia	c or respiratory a	laulsto urrest,	WII, II	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	a Sepsis						Onset and Death
	/Medical Examiner		resulting in death)	Due to (o as a consequ	C 1	v 4				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	Sche Jence of):	mia				10 hours
	cuted nd ransit	Examiner	that initiated events	C						
760.	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
687	9 % 0	edical		d						
Box	h certi ending use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar				23d. D	ate of delive	ery
	e deat the attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		topic pregnancy her (specify)		A	Month	Day Year
P.0	that the de	Phy	9 Unknown Part II. Other significant conditions	23a Did t	obacco use co	ntribute to th	ne cause of death?			
Records.	quires n sign	d by	Hypertension					Yes 25 No		ably 4 □Unknown
000	law requir as been si 2 should	ompleted	_ Celiac Sprue				24a. Was		. Were auto	psy findings available
	The I	Com					auto perfo 1 ☐ Yes	rmed?	death?	npletion of cause of 212 No
Division of Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:			ath (Check only o			-
ō	Phys or this oral dii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Lympatient 2 L	ER/Outpatient 28b. Time of	3□ DOA Other: 4□ Nursing H 28c. Injury at Work?	lome 5 Resi			′)
ion	ttending F death. ctor: Atter	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	Injury	Work? M 1 ☐ Yes 2 ☐ No				
ivis	or Atter de lirecte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street,	factory, office	28f. Location (. City or To	Street and Nun vn, State)	ber or Rura	Route Number,
	spital ours a serat C		29a. Certifier 1 Certifying Pt	nysicien: To the best of my know	wledge, death as	gurad at the time, data and place				
	To the Hospital or Attending Physician: The law requires that the death certilica within 24 hours after death. To the Funeral Director: After this certilicate has been signed by the attending phy completely tilled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	ion and/or invest	igation, in my opinion, death occu	rred at the time,	date and place	anner as st , and due to	the cause(s)
	To the To the Complex	Σ	29b. Signature and title of certifier	:		29c. License number		29d. Date sign	ed (Month, I	Day, Year)
	7		1 oun t	llun, MD		RES-000		tzugust	31,	2.004
	10		30. Name and address of person who		23a) (Type, Prir		= f. A	A) T. A	ADZ	
	Sta	-	31. Date filed (Month St. Pear)	2004 32. Redistrar's Signati	ure A	THE PROOF TIME	15 (6	,	U.K.C	
State Registrar 31. Date filed (Month, S.P. Peal) 7 2004 32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RNINA 40A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death enter Year If Under 24 Hrs. BALTIMORE If Under 1 Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M 2 KF Days Months Hours 220-24-368 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic svent, the Mcdical Examiner nust be notified at MD Director BALTIMORE TOWSON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 RYMMORE USA or items 23a 100 by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is markad other than ' Elementary/Secondary (0-12) College (1-4or 5+) President 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baugher Henri atherine 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD wiew 20c. Location - City or Town, State Darker hushand Dwarth more 100 MD 21204 Baltimore, 20b. Place of Disposition (Name of cometer); crematary or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill, MO * 4 ☐ Donation * 5 ☐ Other (Specify) 9-6-04 22. Name and Address of Facility 2325 YORILRO. TIMONIUM MO PEACEFUL ALTERNATIVES FUNERALY CREMATION CITE 23a, Part1. Enter the disease or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nonthe Due to (or as a consequence of) 200 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospice 2 1 ☐ Yes 🤌 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 4 7004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

Amon Cha 31. Date filed (Month, Day, Year)

6601 N. Charles St

Towson, Md. 21204

			_ FOI	yland / Departr	ment of Health and	Mental Hy	giene
			1 _ State Registrar	Certif	icate of Death		Reg. No. 004 28050
	Dharaint		Decedent's Name (First, Middle, Last)	. 0	_	2. Date of De Month	ath Day Year 3. Time of Death
	Physicia /Medic		THOMAS FLANCE	15	rown	SEPT	4,2004 08=12 M
	Examin		4a. Facility Name (If not institution, give street and number)		. City, Town, or Location of Deat	h	4c. County of Death
			HAZFOND MEMORIAL HO:		<u> </u>	TRACE	HARFORD
	Funeral		10KM 2015		Under 1 Year If Under 24 Hrs onths Days Hours Min.		th y, Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	77115.		14-2	-35 MARYLANDS
	and and	}		10c. City, Town or Location	on	***	10d. Inside City Limits
	Mary 1 sho	ō	MN Harford	Porc	0.11:20		1 ☐ Yes 2 No
	28e	Director	10e. Street and Number	Δ 1	Of. Zip Code		10g. Citizen of What Country?
	death with the Maryland ms 23a or 28e-f show r must be notified at	₫	1020 Sysauphana	Ave.	21902		USA
	death	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. Was	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puer	Specify Yes or No	- 14. Race - American Indian,
٥	or Ite		1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	10	Yes 2 No Specify:	to riican, etc.)	Black, White, etc.
920	n 72 hours after death with the Marylan "neturel", or Items 23e or 28e-1 show edical Examinat must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:				white
ក	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occupation of work done during most of wo	rking	16b. Kind of Business/Industry
7	within ene. than "	dμ	Elementary/Secondary (0-12) College (1-4or 5+)	irre. DO I	NOT use retired)		41.4
2	e filed v Il Hygie other t vent, III	ပိ	17. Father's Name (First, Middle, Last)	-0130	18 Mother's Na	me /First Middle	Maiden Sumame)
au	0 0 0 0	Be	Parison and Barrell		1000	Maria	Vanharite
Ē	hould Me In	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	ddress (Street and Number or Ri	ural Route Number	er, City or Town, State, Zip Code)
Ma	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		Brumond BROWN BROW	(money	MATTHEWALL	iAnde	NEEN: 110 GA BANKI
ā,	Heal Heal tem 2		20a. Method of Disposition	20h Place of Disposition	n (Name of	Date	20c. Location - City or Town, State
<u> </u>	9° = 5		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)	Cemetery Cremato	A (O)	9-14	FOREST HILL, MD
			21. Signature of Funeral Service Licensee	22. Na	ime and Address of Facility	171'MA1	25, m021234.
ğ	permit. Departr Importe any inju		Kimiladu (). Balluste	2 FURL	US FOLLERAL C	NAPPI S	SKOOHARFORD RD
			23a. Part . Enter the disease, or . mplic flors that it used the shock, or heart failure. List inly one cluse on each line.	e eath. Do not enter th			
ı,	hysician		Immediate Cause (Final	HASCU			Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a condition along the conditio	consequence of):			
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	n =	ner		consequence of):			
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: و ×	ding p	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy			23d. Date of delivery
Š Q	atten for u	lan	in the past 12 months?	☐Fetal death 3☐Ecto	opic pregnancy ner (specify)		Month Day Year
j	w requires that the death certific been signed by the attending p should be detached for use as	hysiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				
Τ.	that led by deta	۵.	Part II. Other significant conditions contributing to death but	not resulting in the under	lying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?
Records,	n sign	d by				1 🗆 Y	res 2 □ No 3 🗖 Probably 4 □Unknown
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	Physicien: this certific ral director,	To B	examiner? 1 ► Yes 2 □ No Hospital: 1 □ Inpatient	2 AER/Outpatient 3	Other: 4 Nursing h	fome 5 ☐ Resid	dence 6 ☐Other (Specify)
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DIVISION	or Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, street, f (Specify)	factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, n, State)
ב	urs af oref D						
	Hosp 24 hor Fune felly fi	edical	29a. Certifier 1 □ Certifying Physician: To the best of ((Check only one) Medical Examiner: On the basis of examiner on the basis of examiner.	xamination and/or investig	curred at the time, date and place gation, in my opinion, death occu	e, and due to the our erred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
	⊢ ≯ ⊢ ŏ		Many and rubben	~ DME	D 21809		SEPT 4 2004
	181		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, Print			
	71		95 PLASHUMD 233		NOMIT au	ium n	1021093
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's				
	Registr	ar	OLFU / LUU4 Aller	A. Carel			

State of Maryland / Department of Health and Mental Hygiene

				Clate of W	ai yiai i	•			Death	Wientan ny	Reg. No.)	0.1	20051
		_	1. Decedent's Name (First, Middle, L.							2. Date of De		1)4	3. Time of Death
4	Physicia		Lillian	Bow	les					Sep+	Day P 3	2004	11:35 AM
	/Medica Examine		4a Facility Name (If not institution, gi						4b. City, Town, or			ty of Death	
	- LAUTHITO	5	Manor Care Towso	n					Towson		Balt	imore	
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs.	last birthday)		r 1 Year	If Under 24 Hrs.	8. Date of Bi			ace (State or Foreign
	Director		220-20-7718 Usual Residence of Decedent	1□M 2)X[F		8 4 Yrs.	Months	Days	Hours Min.	Mar 6	, 1920		vland
	ter death with the Maryland frems 23s or 28s-f show inst. mast be notified at		10a. State 10b. County			y, Town or Lo						10	0d. Inside City Limits
	the A	ğ	MD N/A 10e. Street and Number		Ва	Itimor	e 10f. Zip	Codo		10g. Citizen of What Country?			
	To a	ਨੂੰ					100						
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020	72 hours efter death with the Maryland natural, or frams 23a or 28a-f show lical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:			Yes, spe		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes of No o Rican, etc.)	Speci	ack, White, e	itc.
5-0	72 ho	1	15. Decedent's E	ducation		16a. Deced	ent's Usu	al Occup	ation	tina	16b. Kind of E		
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D	Hyg Hyg	ا ق	17. Father's Name (First, Middle, Las	")					18. Mother's Nar	ne (First, Middle	, Maiden Surna	me)	
a	d be sortal	To Be	Herman Willig						Tressie	Mast			
Maryland	shoul mark mats	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	a Address	s (Street	and Number or Ru		er City or Town	State Zin I	Code)
S	d2s than 7 Is trau	- 1	Barry Bowles/Son				-						•
a)	1 an Heal Pm 2 ther		20a. Method of Disposition	•	20b. P	lace of Dispos	sition (Na	me of	Dr. #12	Date Date	20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours eft Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "natural; or any Injury or other traumatic event, the Medical Evandonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	0	emetery, crem nesapea	netory or o	other place		Sep 4 2004	Beltsv	•	
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service Lice	let 1	1009	(80)	Crema	atio	ss of Facility n and Fur en Pastur	neral Al			140
	NICON SEL	-	23a Test Inter the disease or con	polications that cause	d the death							imore	
	Physician		23a. Fartt. Enter the disease, or con shock, or heart failure. List only										Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) A MYO CARDIA In furction Due to (or as a consequence of): ORGANIC Brain Syndro										10 min
		6		~	Due to (o	r as a conseq	uence of):		C	1		1	12 . 1
	nsit			b				ail	SIN	drome-		i	12 months.
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68760,	rificate be axecuted ng physician and as the bunial-transit	wedical Examiner	resulting in death) Last		Due to (or	as a consequ	ience of):					1	
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ă	atta	20	David Adam to the control of the con										
P.O.	y the	Prysiciany	Part II. Other significant conditions	contributing to death b	ut not resu	ilting in the un	iderlying c	ause give	en in Part I.				the cause of death?
	as that the daath cer igned by the attandir be detached for usa	2								1	Yes 2□ No	3 ☐ Probe	ably 4⊠Unknown
of Vital Records,	requir seen s should	completed b									an autopsy rmed?	avai	e autopsy findings lable prior to pletion of cause eath?
æ	he is te ha age	E								10	yes 2 No	1 🗆	Yes 2□ No
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o	A = 6		27. Manner of Death	28a. Date of Inju		28b. Time of		28c. Injury Work			now injury occur		
0	dlng th. Afta		1 Stratural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	М		k? Yes 2∐No				
Division	tal or Attending P rs efter death. al Director: After t led in by the funers	e Lilica	3 Suicide 6 Could not be determined	e One Diese of In	ury - At ho c. (Specify	me, farm, stre	et, factory	y, office		28f. Location (S City or Tox	Street and Numi vn, State)	ber or Rural	Route Number,
	To the Hospital or Attending Phywithin 24 hours efter death. To the Funeral Director: Aftar thi completaly filled in by the funeral allocations.	nica: C	29a. Certifier 1 Cretifying Pt (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner st	fexaminat	wledge, death ion and/or inv	occurred estigation,	at the tim	ne, date and place pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as ste and due to t	led. he cause(s)
	thin the mple		29b. Signature and title of certifier	and manner st	u.0U.		200	License	a number	-	29d. Date signe	nd (Month D	av Yaari
	7.¥ 5 8		Los. Signature and little of certifier			> m			57740				
	10										Sept	2	4007
	/,	;	30. Name and address of person who \$50 (JH) A	completed cause of c	eath (Item	23a) (Type, F	Print)	70	wson,	MO	21234		
	State		31. Date filed (Month Par) Y 7 201	4 Maris	ar's Sigra	ure 600							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygiene

			1- For State of Maryland / Dep	eartment of Health and Mertificate of Death		ne .n2 0 0 4	28052			
	Pĥysici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day 3, 2 Year 4	3. Time of Death			
,	/Media	ċal	Anna K. Burkindine 4a. Facility Name (If not institution, give street and number)	er 3, 2004 10:10 p M						
	Examir	ier	Gilchrist Center for Hospice Care	4b. City, Town, or Location of Death TOWSON		Baltimore				
	Funeral Director		5. Social Security Number 218-12-0380 6. Sex 1 □ M 2 ★ 7. Age (In yrs. last birthday 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Sep 22,	ear) 9. Birthp County 1919 Mary	oface (State or Foreign Pand			
	aryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		1	Od. fnside City Limits			
	a-t sh	ctor	MD Baltimore Baltimor	e e			1 Yes 2 No			
	vith the	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Cour	,			
	ns 238	Funerai	7338 Chesapeake Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	21220 Was Decedent of Hispanic Origin? (Spe		United States 14. Race - American Indian,				
36	should be filled within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or Itams 23e or 28e-t show umatic event, the Medical Exercitive reneal to refilled at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: White	etc.			
ב ה	72 hou natura iical E	eted	15. Decedent's Education 16a, Dec	edent's Usual Occupation e kind of work done during most of worki	161	b. Kind of Business/In	dustry			
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and	2 should be filed with and Mental Hygiene Is markad othar thai aumatic avant, the In	Be	17. Father's Name (First, Middle, Last) William Henry Hartung		(First, Middle, Mai	iden Sumame)				
Maryle	should nd Mer marks matic	은		Mary King Address (Street and Number or Rura		ity or Town State 7in	Cadal			
	alth ar			Kittendale Circle,						
baltimore,	of He of He It itam		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cometery, creation, 3 Removal from State		ep 4	c. Location - City or To	own, State			
Ě	t. Pag tment rtant: I			ake Crematory 2	004 B∈	eltsville,	MD			
8717 Green Pastures Drive Baltimore, MD										
	Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of):									
,00/00,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit									
C. DOX	t the death certific by the attending p ached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year			
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אוומו חפכי	in: The law requificate has been or, page 2 should	e Completed	25. Was case referred to medical		24a. Was an autopsy perform 1 Yes 2	prior to con death?	osy findings available inpletion of cause of			
5	ng Physicia Iter this cert neral direct	To B	axaminer? 1		The second secon)			
DIVISION	To the Hospital or Attanding Physician: The law within 24 bours after death. To the Funaral Director: Atter this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 Tes 2 No	8f. Location (Street City or Town, St	t and Number or Rura. tate)	l Route Number,			
	he Hospit: n 24 hours na Funara sletely fille	Medical C	29a. Certifier (Check only one) 1 Sertifying Physicien: To the best of my knowledge, deal of the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a livestigation, in my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)			
	To the within to the comp	M	29b. Signature and tyle of certifier	29c. License number		Date signed (Month, L Stember 4				
	19		30. Name and address of person who completed cause of death (ftem 23a) (Type, Charles W 660 /	Print). Charles T	Tayson	m02120	04			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 2004	les .						

50	J4		1 - For State Registrar	State of Mar		artment of F rtificate of		Mental Hy	rgiene Reg. Nd.) / / /	1 20050	
	Physici /Medi		1. Decedent's Name (First, Middle, L Jeffrey Scot	•				2. Date of De Month Septem	D	3. Time of Delath 00:08 A.M	
	Examir	ner	4a. Facility Name (If not institution, gr 6901 Spring Hill 5. Social Security Number 6.	Drive	(In yrs. last birthday)	4b. City, Town, of Sykesvi	r Location of Dea		4c. County of Death Carroll County		
	Funeral Director		220-48-8100 Usual Residence of Decedent	17 M 2□F 49	Yrs.	Months Days	Hours Min		ay, Year)	9. Birthplace (State or Foreign Country) 1d	
:	death with the Maryland ms 23e or 28e-f show rriust be notified at	Director	Md Carroll		Oc. City, Town or Lo Sykesvi					10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo	
:	sath with the 23e or 2		10e. Street and Number 6901 Spring Hi			10f. Zip Code 21784			10g. Citizen of Wh		
0000-0	should be filed within 72 hours after and Mental Hygiene, in marked other then "naturel; or ite umetic event, the Medical Examina	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ∰ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 Tho If Yes, Give A Year or Dates:		Was Decedent of H I Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (San, Mexican, Puei Specify:	Specify Yes or No to Rican, etc.)		American Indian, White, etc. White	
0.01212		Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired PAINTET	ation during most of wo	nrking	home im	ness/Industry	
yland		To Be C	17. Father's Name (First, Middle, Las Louis Stanley B	ranick Jr.		· · · · · · · · · · · · · · · · · · ·	Carole 3	Jane Olf			
1			19a. Informant's Name/Relationship Carole Branick (20a. Method of Disposition	mother)	6901	Spring H	ill Dr.,		er, City or Town, St ille, Md 20c. Location - Co	21784	
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		1 ☐ Burial 2 【**Cremation 3 (Removal from State	All Count	natory or other place y Cremat	ion 9-6-	04	Sykesvill		
			23a. Part1. Enter the disease, or con shock, or heart lailure. List only	Serbert	P.	0. Box 19	95 Sykes	ville, M	id 21784	Approximate Interval Between	
	hysician hybrician and hybrician and hybridian-transit transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequential, list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CWO Co. Due to (or as a co. Due to (or as a co. Due to (or as a co.		Hemor	vnage				
de death and different	been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of Month	*						
ooriiroo that	en signed b	by	Part II. Other significant conditions	contributing to death but n	not resulting in the ur	iderlying cause give	en in Part I.		obacco use contribu	ute to the cause of death?	
The law r	certificate has be ector, page 2 sh	Completed							osy prio rmed? dea	re autopsy findings available or to completion of cause of th? Yes 2 \(\square\) No	
the Hoenitel or Attending Diversion.	fter this	Certification: To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	28a. Date of Injury (Month, Day Ye		er: 4 ☐ Nursing F	Death (Check only one) g Home 5 Residence 6 Cother (Specify) A S 28d. Describe how injury occurred				
ospital or	5 축금 드	edical Cert	29a. Certifier 1 ☐ Certifying Pl	building, etc. (S	ny knowledge, death	occurred at the tim	e, date and place	o, and due to the	Cause(s) and mann	er as stated.	
Tothe	within 24 hours a To the Funerel I completely filled	Medi	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 1, 2004								
	4		30. Name and address of person who	TLLAN IV	£1	Penn Stre	et, Balt	timore, 1	Maryland	21201	
	Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's	oignature L	1 .					

DHMH 17 Rev 1/2001

ORIGINAL

٤		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			jiene	4 28051
Physic /Med	ical	1. Decedent's Name (First, Middle, Last) OSEGA 4a. Facility Name (If not institution, give s		ealo	4b. City, Town, o	r Location of Deat	2. Date of Dea Month	Day Y	Year 3. Time of Death
Exami Funeral Director	P	No A Tetwes 5. Social Security Number 6. Sex	HESpita	(In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	ساسا	BAI	9. Birthplace (State or Foreign Country) Massachusett
ith the Maryland or 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Carroll 10e. Street and Number 1695 Gemini Rd		10c. City, Town or Lo Eldersb	urg	.784		I 0g. Citizen of Wh	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f show event, the Medical Exprire months.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	2. Was Decedent E Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates:	1967 16a. Dece (Give iite.	Was Decedent of Hif Yes, specify Cub. 1 Yes 2 No dent's Usual Occup, kind of work don's DO NOT use retires tomobile	dispanic Origin? (S an, Mexican, Puerl Specify: bation during most of wor d) Mechanic	rking	14. Race-Black, Specify: 16b. Kind of Busi	ile Repair
ed la	To Be	17. Father's Name (First, Middle, Last) Carmine Buca 19a. Informant's Name/Relationship (Type)	oe, Print)		ng Address <i>(Street</i> 95 Gemini	Mar	y Rippar	r, City or Town, St	tate, Zip Code)
Ore, pes 1 ar of Hea if item ?		Marilyn Bucalo - 20a. Method of Disposition 1 Burial 2 Acremation 3 R 4 Donation 5 Other (Specify)		20b. Place of Dispo cemetery, cre		ce)	Date	20c. Location - Ci	ity or Town, State
Baltim permit. Pag Department Importent: any injury o		21. Signature of Funeran Service Ligense 23a. Part . Enter the disease, or compli	hard 7			eistersto	wn Rd.,	Owings M	21117 ills, Md.
BY60, cate be executed /Medical Examiner physician and the burial-transit		shock, or he fit failure. List only on the immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	0090	FIBRILL	PHACEP.	GARDIAC	Acres	Interval Between Onset and Death
. Box 6 death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Month	· ·
<u> </u>		Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	inderlying cause giv	ven in Part I.			oute to the cause of death?
	Completed by	Hypentense	'on; !	Expiration.	tony 7	Hiluse	24a. Was a autop perfor 1 \(\triangle \triang	sy prid	ere autopsy findings available or to completion of cause of ath?
ISION Of ttending Phys death. stor: After this tthe funeral di	Certification; To Be	27. Mann, of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Dimpatier 28a. Date of Injury (Month, Day)	28b. Time o	of 28c. Injui Wo M 1	ner: 4 Nursing H	28d. Describe h	ence 6 Other ow injury occurred	
DIV To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical Cert	(Check only 2 Medical Examin	sician: To the best of	f my knowledge, dea examination and/or ir	th occurred at the ti			ause(s) and mann	ner as stated. Indicate to the cause(s)
To the within 2 To the complei	Med	29b. Signature and title of certifier	and manner stal	hij)	29c. Licens	se number	2	29d. Date signed ((Month, Day, Year)
)	30. Name and address of person who co	mplered cause of de	nath (Item 23a) (Type	Print)	RANDA	HUEST	Hospi	(AL GOVERS
S Regis	tate trar	SEP 0 7 2004	Stope	D. Age					

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State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygiene
			Registramend TTEM #20b&c PER FH G835 9/07/04 9H Peath Reg. No. U 28055
	Physici	an	1. Decedent's Name (First, Middle, Last) ARTIN Y BERN STEIN 2. Date of Death Month Day Year 1. Time of Death Month Day Year
	/Medic		ARRUST 31 CECY T P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 10 CTHWEST HOSPITAL 4b. City, Town, or Location of Death 10 CTHWEST HOSPITAL 10 CTHWEST HOSPITAL 11 CTHWEST HOSPITAL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth North, Day, Year JAN 18, 1943 MARY LAND
	Director		216-42-7325 TXM 2 F 61 Yrs. Months Days Hours Min. JAN 18, 1943 MARYLAND Usual Residence of Decedent
	yland		10a. State MD BALTIMORE 10c. City, Town or Location OWINGS MILLS
	e Mar	Funeral Director	1 Yes 2 No
	with th	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath is 23,	erai	31 STRAW HAT RD., APT. 2-B 21117 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
21215-0036	tiges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Macital Examinar must be maillised at	by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, Specify:
5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working
121	within ene. than "	Jumo	Elementary/Secondan (0-12) College (1-4or 5+) SECURITY GUARD SECURITY
<u>5</u>	i Hygid othar ant, II	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	should be and Mental marked o	To B	SIDNEY BERNSTEIN FLORENCE SCHNEIDERMAN
Mar	d 2 sho th and t7 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN BERNSTEIN (WIFE) 31 STRAW HAT RD., #2-B OWINGS MILLS, MD 21117
ē,	s 1 and f Health item 27 othar tr		20a. Method of Disposition Date 20a Assettors & Etteron Turn, State
altimore,	Pages nent of I ant: If its ary or o		1 M Burial 2 Cremation 3 Removal from State *A Donation 5 Other (Specify) **RUGAM GASTICLE MILES, MD
Balt	permit. Pages Department of Important: If i any injury or concept.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.
	0.□ <u>F</u> # 0(8900 REISTERSTOWN RD PIKESVILLE, MD 21208
	D		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):
	Examiner		ACCVO
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to leave to l
	xecution and af-tran	хап	cause Creasa or righty that initiated events resulting in death) Last Due to (or as a consequence of):
68760,	ficate be executed physician and is the burial-transit	edicai Examiner	d.
	- m =		IF FFAME
Вох	ath ce ttendii	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
P.O.	The law requires that the death certifies that been signed by the attending rage 2 should be detached for use a	Physician/M	In the past 12 months? 1 Yes 2 No
σ.	that the part of t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	aquires en sig		COPO DAIL HTN 1 Yes 2 No 3 Probably 4 Unknown
ecc	in as a	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of
<u>~</u>	cate h	Con	performed? death? 1 ☐ Yes 2 ☐ 1 ☐ Yes → 1 ☐
<u> </u>	sician: Th certificate irector, paç	o Be	25. Was case referred to medical examiner? 1 Yes 2 No. 1 Yes 2 Yes
0	g Phys er this eral dii	\vdash	27. Manner of eath 28a. Vate of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ior	Attanding Physician: r death. ector: After this certifice by the funeral director.	atio	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No
Division of Vital Records,	I or Attank after death Director: in by the	Certification:	3 Suicide 6 Could not be determined Called Mumber of Rural Route Number, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a. Certiflier Chock cold. C
	To tha Hos within 24 h To tha Fur completely	edicai	(Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To tha within 2 To tha complet	X	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
	^		D37333 AUGUST 31,2004
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. LAVI MPN HC, SALTO MO 21133
	Sta Registra		31. Date filed (Month, Day, Year) SEP 0.7 2004 Server A About /
		-11	SET II / / IIII APTOT AN ANDERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Sept. 2004 4:45 A M Anna E. Chepaitis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Elizabeth's Nursing & Rehab Baltimore None If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 1 F 89 March 17,1915 Maryland 216 05 0316 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ehow ms 23a or 28a-f ehov 1 Yes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 4018 Bright Rocket Way United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 11. Marital Status r than "neture!", or iten filed within 72 hours after 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Clerical Worker 10 Social Security Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Benedict Plungis Elizabeth Semanes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ... Health a Jo Anne Knapp/Daughter 4018 Bright Rocket Way Ellicott City, MD 21042 iten. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If its eny injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-8-2004 Holy Redeemer Cem. * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. permit. 21. Signature of Funeral Service Licensee Colons-M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mell 4225 **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 2⊠ No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ሼ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sept 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chone lang 720 elena. Lo 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 07 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year jounts Illywood 0.45AM 28 /Medical 2004 Randallstown

| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| 12 20 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F intry) SC Yrs. Director 214-12-8959 Usual Residence of Decedent death with the Maryland 10a. State ehow. 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryla. of Health and Mental Hygiene. Iftem 27 is marked other then "natural", or items 23a or 28a-1 ehov other traumatic event, the Medical Examinar must be notified at Director XX es 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 2338 North Monroe Street 21217 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced Specify. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver na Good Humor Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Hill George Counts 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Lillywood Therland Counts Jr. 4412 Old Court Road Apt B. Pikesville MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of h 20c. Location - City or Town, State permit. Pages Department of Important: If it any njury or o Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 9/7/04 Baltimore, Md 21. Signature At Euperal Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple organ disease or condition resulting in death) 6 hours /Medical Due to (or as a consequence of Examiner semic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury int DOTAL yndrom & Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit eritoniti signed by the attending physician and I be deteched for use as the second that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical Ischemic IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pertension 2 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Didemia 24a. Was an has autopsy performed; Prostate cancer 2 🗀 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ۵ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 DNatural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred s after decreight of the street of the stree 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) woolon MD August 28, 2002 D28462 person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland 21133 Hospital Bos Northwest 32. Registrar's Signature 31. Date filed (Month, State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 5:30 PM Robert F. Crook, Sr. 2004 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth Maryland Masonic Home Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 6, 1916 Birthplace (State or Foreign Country) **Funeral** Director 88 Yrs 212-05-6871 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Marylend and Mental Hygiene.

is marked other then "netural", or items 23a or 28a-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23a 14201 Quail Creek Way 21152 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metalurgist Armco Metal/Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter G. Crook Agnes Pentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Vera A. Crook/Wife 14201 Quail Creek Way Sparks, MD 21152 20b. Place of Disposition (Name of 20a. Method of Disposition Sept. Date, 20c. Location - City or Town, State Moreland Memorial Park Cemetery Department of Importent: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD 21. Signature of Funeral Bendee Licensee Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Fragle 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chrosis Liver **Physician** 0) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Cancer has autopsy performed? certificate 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeref Direct 4 Homicide LEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 9/5/04 21464 NUS

Registrar

10

State

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Roon, Rolen

BAZ 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2004

KOBERT LIBERTO, 31. Date filed (Month, Day, Year)

MD. 3508 BANK

32. Registrar's Signature

Physici /Media Examir **Funeral** SEPTEMBER 3, 2004 @ 6:02 AM Director permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparement of Health and Mental Hygiene. Importent: if Item 27 is marked other than *natural*, or Items 23a or 28a-f show any injury or other traumatic event, the Mardical Examinar must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar 1. Decedent's Name (First, Middle, La		-	Certificate of		, ,	eg. No.	28050
ian cal ner	Raymond Will 4a. Facility Name (If not institution, giv	iam Chen			or Location of Death	Septembe	Day You	6:02 a™
	Gilchrist 5. Social Security Number 6. S	Sex 7. A	ge (In yrs. last birt	Towson Thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 30	Baltin	Birthplace (State or Foreign Country)
,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		Aug Ju	, 1943 Ma	10d. Inside City Limits
Director	Md. N/A 10e. Street and Number 4100 Montana A		Baltim	10f. Zip Code	206	1	0g. Citizen of What	1√2 Yes 2 □ No Country? JSA
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		dispanic Origin? (Spe an, Mexican, Puerto	acify Yes or No- Rican, etc.)		merican Indian,
Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		5+) _	Decedent's Usuat Occup (Give kind of work done life. DO NOT use retired Lectrician	during most of worki	ng	16b. Kind of Busines	,
To Be C	17. Father's Name (First, Middle, Last, Raymond W. Chend	oweth, Sr.			18. Mother's Name	nia Rim	nehart	
	19a. Informant's Name/Relationship (Mrs. Alice Chenows 20a. Method of Disposition		20b. Place of	Mailing Address (Street 4100 Montan Disposition (Name of	a Ave. Ba	ltimore	-	06
	1 Burial 3 Cremation 3 C 4 Donation 5 Other (Specif	ý)	1 1	y, crematory or other place p Service C 22. Name and Addre Ruck To	ss of Facility	ral Home	Towson, M ∍, Inc.	1d.
	23a. Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	a. St	ine. Volke	1050 You	rk Rd. To	wson. Mo	1. 21204	Approximate the therval Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequence of	id hemorn	chase			weeks
ledicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	cal as	neu pysm			_	weeks
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	/		23d. Date of d Month	leiivery Day Year
by	Part II. Other significant conditions of	contributing to death l	but not resulting in	the underlying cause giv	ren in Part I.			to the cause of death? Probably 4 Unknown
Completed						24a. Was a autops perform	y prior to	
ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpati	ury 28b. T	njury Wor	y at	ne 5 ☐ Reside	4.5	pecify) Wespice
Certification;	3 Suicide 6 Could not be determined	e 28e. Place of In	itury - At home, fai tc. <i>(Specify)</i>	rm, street, factory, office	-	28f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
Medical	(Check only 2 Medical Examone)	nysician: To the best miner: On the basis of and manner s	of examination and	, death occurred at the tir d/or investigation, in my o	pinion, death occurr	ed at the time, di	ate and place, and d	ue to the cause(s)
	29b. Signature and title of certifier	en	d at (10 a 00 a)	29c. Licens	7307		9d. Date signed (Mod	3 ZOS4 40 ZIZO4
ate	30. Name and address of person who A Co	LES N	rar's Signature	W (horles	St 7.	DWSMU	4021261
rar	SEP 0 7 2004	Severa	B	Space				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

RAYMOND CHENOWETH

Baltimore, Maryland 21215-0036

	State of Mary		delible Ink.				ble.	
For State Registrar	State of Ivial		triment of H tificate of L		•	000	11. 0	0001
Decedent's Name (First, Middle,	Last)				2. Date of De	Reg. No.	14 /	3. Time of Death
Harry Page					Sept.	Dav	Year	
4a. Facility Name (If not institution,			4b. City, Town, or	Location of Dr		3, 2004 4c. County		5:50 A M
Franklin Square			Rosed		3ain			
		In yrs. last birthday)	If Under 1 Year	Id I E If Under 24 F	Hrs. 8. Date of Bir		altimor	/Ctn to as Fornian
217-18-9849	18 M 2□F	81 Yrs.	Months Days		fin. Oct. 1	y, Year)	Country)	rginia
Usual Residence of Decedent		01			000. 1	1, 1722	y 1	rginia
10a. State 10b. County	10	Oc. City, Town or Loc	cation				10d.	Inside City Limits
Md. Bal	ltimore	Pa	rkville					1 ☐ Yes 2 🔀 No
10e. Street and Number	OTHIOT O		10f. Zip Code			10g. Citizen of V	What Country?)
8820 Walther E	Blvd. Apt. 2	2212		1234		US	•	
11. Marital Status	12. Was Decedent Eve	er in U.S. 13. W	Vas Decedent of His	spanic Origin?	(Specify Yes or No		o - American I	ladian
1 Never Married 2 Marrie	Armed Forces? ad 1 ☐ Yes 2 📉 No	lf.	Yes, specify Cubar	i, Mexican, Pu	erto Rican, etc.)		ck, White, etc.	ficiali,
3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify	· Wh	nite
15. Decedent's	s Education	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Bu		
(Specify only highest Elementary/Secondary (0-12)	T T	(Give k	kind of work done d OO NOT use retired)	uring most of v	working	1961	13111004	'y
Elementary/Secondary (C 1-2)	College (1-4or 5+) 4	Sale	es Manage	r		Pac	ckaging	,
17. Father's Name (First, Middle, La	ast)				Name (First, Middle,			
Frank R. Ches	rear						<i>-</i> ,	
JI WIIIS INC.	,261			K 11.	- ' FIMA			
19a. Informant's Name/Relationship	n (Tvoe. Print)	19b. Mailing	· Address (Street a		th A. Ewe		Otato Zin Coo	*. 1
				nd Number or	Rural Route Number	er, City or Town,		
irs. Elizabeth A. 20a. Method of Disposition	. Chesser/Wife	e 8820 V	Walther B	nd Number or 1vd. Ap		er, City or Town, Parkvill	e, Md.	21234
Irs. Elizabeth A. 20a. Method of Disposition 1□Burial 2★Cremation 3	Chesser/Wife	e 8820 V	Walther B sition (Name of latory or other place	nd Number or lvd. Ap	Pural Route Number pt. 2212 Date	Parkvill 20c. Location	e, Md. City or Town,	21234 State
Irs. Elizabeth A. 20a. Method of Disposition 1 □ Burial 2 位 Cremation 3 14 □ Donation 5 □ Other (Spe	Chesser/Wife	e 8820 V 20b. Place of Dispos cemetery, crem. Hilltop Se	Walther B ention (Name of latory or other place ervice Co	nd Number or 1vd. Ap	Pural Route Number pt. 2212 Date /4/04	Parkvill 20c. Location	e, Md. City or Town,	21234 State
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Prs. Elizabeth A. 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List or	Chesser/Wife	e 8820 V 200b. Place of Dispos commetery, crem. Hilltop Se	Walther B sition (Name of latory or other place ervice Co Name and Address 050 York	Ivd. Ap	Pural Route Number pt. 2212 Date /4/04 Ruck Towson, Ma	ar, City or Town, Parkvill 20c. Location Towson on Funer aryland	e, Md. City or Town, Maryla al Hom 21204	21234 State and ne, Inc. proximate
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Rrs. Elizabeth A. 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Special Company) 21. Signature of Funeral Service List of Shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	Chesser/Wife 3	e 8820 V 20b. Place of Disposementery, crem Hilltop Secondary, crem Line death. Do not enter Lin	Walther B sition (Name of atory or other place ervice Co Name and Address 050 York If the mode of dying	nd Number or 1 Vd. Apply 1 Pp. 97 Sof Facility PROAD 1, such as card	Pural Route Number Pt. 2212 Date /4/04 Ruck Towso Towson, Mailiac or respiratory ar	Parkvill 20c. Location Towson On Funer aryland rest, 23d. Date Mon	e, Md. City or Town, Maryla Pal Hom 21204 Apprinte On:	21234 State and ne, Inc. proximate erval Between set and Death Year
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Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or Items 23a or 28a-t show any injury or other traumatic evant. The Medical Examinational be rediffed in once.

To Be Completed by Funeral Director

Fra 19a. Informar Mrs. El

Physician /Medical

Examiner

Funeral Director

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical

Sequentially lift any, leading cause. Enter Cause (Diseas that initiated extends the cause of the cau Examiner resulting in de IF FEMALE: 23b. Was dec Part II. Other s 25. Was case examiner? Medical Certification: To 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day, Year) SEP 0 7 2004 State

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

1 Natural

32. Registrar's Signatur

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item #5 per FH 11:1:04 G837.11-1-04 TT State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:46 P M Inez F. Carr 2004 September 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner stember 1,2004 Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months Director Jan 7, 1919 West Virginia Usual Residence of Decedent with the Maryland Wode 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28a-f ehor 1 Yes 2 No Director MD Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Kenilworth Park Dr. 1A 21204 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify White Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Bendix njury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Farmer Mary Dingess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 102-1A Kenilworth Park Drive, Towson, Md. 21204 <u>Gary Lee Carr/son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/07/2004 * 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grdns. Timonium, MD. 21. Signature of Fundral Service Ligensee 22. Name and Address of Facility Ruck Towson Funeral Home, S. Coster 1050 York Road Towson, Maryland 21204 23a. Part1. Efter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic Physician years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be exec Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medicai as the esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death Was decedent pregnant in the past 2 months?
1 ☐ Yes 2 ☐ No 23b. Was dec 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has autopsy 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes No 6 her (Specify) 1000 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Ratural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier we of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 20 fembor 2 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. or Dollewore un

Registrar

State

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31. Date filed (Month, Day, Year)

32. Registrar's Signatur,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

SEP 0 7 2004

ORIGINAL

32. Registrar's Signature

			1 - Stete Registrar Co	eartment of Health and M ertificate of Death	Reg. N	@001, 29061
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Pay Year 12:40 PM
	/Medic	al	Albert Edwards	4b. City, Town, or Location of Death	1 10 10 10 10	C. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	Baltimore		Baltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	9. Birthplace (State or Foreign
	Director		223-46-6489	Months Days Hours Min.	3-28-1938	VA VA
П	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	Maryll f sho	io	MD Harford Jopp	a		1 ☐ Yes 2 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	23a c	alD	108 Orsburne Drive	21085		USA
	n 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show colout Exprise contited at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 反 No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
50	irs aft	by F	1 the Never Married 2	1 ☐ Yes 2 ☐ No Specify:		Specify: white
Ş	r2 hou	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b.	Kind of Business/Industry
7	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	9	Marine
2	be filed within 72 hours after death with the Maryland all Hygene. de Hygene. de Other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Modical Exprise or in at finite the rollified at	Col	10 Mac	hinist	(First, Middle, Maide	
au	0 = 0 >	To Be	Delmon Edwards		se Allio	-,
Maryland 21215-0036	2 should be and Mental is marked c	Ė	The state of the s	ling Address (Street and Number or Rura		or Town, State, Zip Code)
Σ	and 2 ealth a n 27 is			5 Deerhaven Rd, Coo		
o G	Pages 1 nent of He int: If iten iry or oth		I IA DUNAL 21 CHANGANDI 3 LIBORIOVALIUM SIAIR I	ematory or other place)		Location - City or Town, State
Baitimore,	t. Pag rtment rtant: njury		'4 □Donation 5 □Other (Specify) Edwards	Cemetery 9/5/ 22. Name and Address of Facility Sin		und, Virginia
g n	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ance.		21. Signator of uneral service Licensee	1 Second Avenue S.V		
	E 5 5 5		23a. Fart1. Enter the disease, or complications that caused the death. Do not e			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1 Falur		Onset and Death
	/Medical		resulting in death) a Due to (or at a consequence of):	1 Innure		1 days
	Examiner	L	Sequentially list conditions, b.			
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enor Uncertains Cause (Disease or injury)			
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last c			
760	0 0 0	cal	d			
200	ntifical ng phy as th	Medi	IF FEMALE:			
ROX	death certificate e attending phys id for use as the	Physician/Medi	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
<u> </u>	0 0 0	yslc	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		
a .	The law requires that the de ste has been signed by the a bage 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rd S	quires in sign	ed by			1 🗆 Yes	2 No 3 Probably 4 Monknown
ဝ္ပ	e law require has been si ye 2 should b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ĭ		Com			performed? 1 ☐ Yes 2 ☐ 1	death?
Vital Records,	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Othor	(Check only one)	
	Physic this cral dir	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ent 3 DOA 4 Nursing Hol	me 5 Residence 28d. Describe how in	6 ☐Other (Specify) jury occurred
Division of	ding f th. : After s funer	Certification:	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation			
N S	or Attendate death Director:	tifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
ā	ital or A irs after ral Directled in by	Cer				non-company
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical	29a. Certifier (Check only one) Check only one of examination and/or and manner stated.			
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	- ≯ - ŏ		Azennam . MD	AT- 24389	46-E10 Se	pt 1, 2004
	2		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	pli. Di	1 MN 51516
	ツ		V FLORELLO SVEN-ERIK QUIANZON	201 East University	TKWy, Pat	17morz MV 21210
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spale		
DH	MH 17 Rev 1/2	- 6	SEP 0 7 2004 Benera B	sparks		

ORIGINAL

	,,		1 - For State Registrar	State of Ma	arylan		artmen rtificate			ind M	,	giene		14	280	155
	Physic	ian	1. Decedent's Name (First, Middle, L								2. Date of De Month	Da	y	Yeer	3. Time	of Death
	/Medi	cal.	Jennie M. Emerson- 4a. Facility Name (If not institution, gr				4h Cih	Tour	Lasstina		Septemb				7:11	P M
1	Exami	ner	Johns Hopkins H				4b. City,		Location o			40.	•	y of Death		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. I	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir	th		9 Birtho	lace (State	or Foreign
	Director		217 02-1020	1□M 2XF	51	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 03-16-1	953		North	Caro1	ina
	and		Usuel Residence of Decedent 10a, State 10b, County		10c, City	y, Town or Lo	cation							1	Od. Inside (Since I describe
	Maryl f sho	Į.	MD N	A			ltimor	e						['		s 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent, Ira Medical Exercities must be notified at	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of '	What Cour		
	23a o 23a o ust be	a D	2438 E. Biddle Street	:			21:	213					SA		,	
	ems ems	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-		ce - Americ		
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣	No	1	1 ☐ Yes 2		Specify:	, 1 00110	riican, etc.,		Specify	ck, White,		
8	72 hours after dea *natural; or items	pa pa	3 Widowed 4 Divorced	Year or Dates:		16a Doss	dontin I lava	1.000						blac		
15	in 72 n na	Completed	(Specify only highest g	ade completed)		16a. Deced (Give life. I	kind of wor DO NOT us	rk done a se retired,	luring most)	of worki	ng	16b. K	nd of Bi	usiness/Ind	dustry	
212	d with giene	E O	Elementary/Secondary (0-12)	College (1-4or 5	o+)		ing Ass						Hea	alth Ca	re	
pu	2 should be filed withir and Mental Hygiene. Is marked other than sumatic avent, Ir a Me	Bec	17. Father's Name (First, Middle, Las	1)					18. Mother	r's Name	(First, Middle,	Maiden	Suman	ne)		
yla	should be tind Mental I	2	Walter H. Malone								R. Mece					
Maryland 21215-0036	12 sh and rem reum		19a. Informant's Name/Relationship			19b. Mailir	g Address	(Street a	nd Number	or Rura	Route Number, MD 212	r, City o	r Town,	State, Zip	Code)	
	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		Tammy S. Malone/ Da 20a. Method of Disposition	ughter	20h PI	lace of Dispo			. Dail		e, MD ZIZ			0: -		
Baltimore,	Pages nent of I ant: If its ary or o'		1 XBurial 2 ☐ Cremation 3 [CE	emetery, cren utus Men	natory or of	ther place	1					City or To	wn, State	
Ē	permit. Page Department of Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Ligarity)		ALDO	1			s of Facility	9 - 07-	2004	Balt	more	e, MD		
Ba	Depared Depared Important in Section 2000 100 100 100 100 100 100 100 100 10		1/1/1/2	han	<u> </u>						. 638 N.	Gi1m	or S	t Balte	o. MD 2	1217
	Pnysician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	a con u	ience of):	Woun	ids u	uth c	Conyc	ilication	S			Interval Be Onset and	Death
,8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):										(The sales)
.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe					2	23d. Dat Mor	te of delive	-	Year
S, P	es tha igned be det	by P	Part II. Other significant conditions	contributing to death bi	ut not resu	lting in the ur	derlying ca	iuse give	n in Part I.		23e. Did to	bacco u	se contr	ribute to the	e cause of o	death?
ord	w require been sign										1 🗆 Y	es 25	⊠ No	3 Proba	ably 4 🔲	Unknown
al Record	The lar ate has page 2	Completed									24a. Was autop perfor	sy med?	P	prior to con death?	esy findings apletion of a	available ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o					
of		To :	1X Yes 2 No 27. Manner of Death	1 LAnpatie		PVOutpatient 28b. Time of		A Cure	' 4 □ Nurs	sing Hon	ne 5 Resid	ence 6	Othe	er (Specify)	
	Attanding in death. sctor: After by the funer	ertification;	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	3-011	Injury	M	Bc. Injury Work?	es 2.∭XNi		- 1			1	at	
Division	or Attandii after death. Diractor: A in by the fu	fica	3 Suicide 6 Could not b	e 28e. lace of Inju	rv - At hor	me, farm, stre					8f. Location (_		er or Bural		her
D	o in Dir	erti	4 Homicide determined	building, etc	: (Specify)	home	, , ,				City or Tow 2438 E.	n, State)			rux M	-
	Hospital 24 hours a Funaral I tely filled	sai C	29a. Certifier 1 Certifying Pl	ysicien: To the best of	of my know	vledge, death	occurred a	t the time	e, date and	place, a	nd due to the o	21150/6)	and mar	nnor ac ets	tod	
	To the Hosp within 24 ho To the Fune completely f	edicai	(Check only one) Medicel Exe	miner: On the basis of and manner sta	examinati	on and/or inv	estigation,	in my opi	nion, death	occurre	d at the time, o	late and	place, a	and due to	the cause(s	;)
	To t To t	Σ	29b. Signature and title of certifier	,			29c.	License	number		2	9d. Date	signed	(Month, D	ay, Year)	
,			Jasha?	heerhee	P M	40		0	.C.M.	E.	5	Septe	emb∈	er 02,	2004	Į.
h			30. Name and address of person who		ath (Item			+	+ D-	1+4-		7		2122		
<i>J</i>	* * * * *	٠	Tasha Z Gree 31. Date filed (Month, Day, Year)	nberg VI	r's Signati		cant 2	тее	L, Ba	TCIN	ore, Ma	ıtyla	3DCL	Z120]	L	
:	Sta Registr		SEP 0 7 2004	Sene		1	200	,								

			State of Maryland / Department of Hea			
		. T	= State Certificate of De 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	28066
	Physici /Medi		GLINTLE LEE FINCH	August	Day Year 29, 2004	3. Time of Death
λ.	Examir	ier		ation of Death	4c. County of Dea	7n
9	Funeral			Under 24 Hrs. 8. Date of Birt	h 9/8in	hplace (State or Foreign
h	Director		44-14-1911/ Yrs.	ours Min. (Month, Da	1927 N	MADHIE
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1111		10d. Inside City Limits
	a-f sh	ctor				1 ≥ Yes 2 □ No
	ith the	Direc	10e. Street and Number		10g. Citizen of What Co	ountry?
	eath v	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar	5	4.7.A	
9	after d or Itan	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	nic Origin? (Specify Yes or No exican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	ncan Indian, e, etc.
003	ural', c	d by	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 No Sp	pecify:	Specify:	ack
215-0036	in 72 l	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use ratired)	g most of working	16b. Kind of Business/	Industry
212	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+)	ir	Home	
and	ould be filed with Mental Hygiene arkad other tha atic evant, II e	Be	17. Father's Name (First, Middle, Last)	Mother's Name (First, Middle,	Maiden Sumame)	
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other than "natural", or items 23a or 28a-1 show maite evant, it a Marical Examir er maite in tilling a	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	HU192 KEA	//	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heatth and Mental Hygiene. artiment of Heatth and Mental Hygiene. Cartant: if itam 27 is marked other than "natural", or Itams 23a or 28a-1 show injury or other traumatic event, it a Madical Examinating the multiple and injury or other traumatic event, it is Madical Examinating the multiple at its injury or other traumatic event.		CLAUDING WATTEN 3 VUMA CA	12) RM 100/1	This/h/M	D 21133
aitimore,	Pages 1:		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
	permit. Page Department o Important: If any injury or once.		*4 Donation / Other (Specify) MITHLEGEX MEMORIA	9-9-04	MIDDLESEX	N.C
Ba	Depa Impo any i		21. Signature of Mineral Segvice/Licenses 22. Name and Segvice/Licenses of April 22. Name and Se	PARCH FUNDAN,	THUME PIA	19
			23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or rear failure. List only one cause on each line.	ch as cardiac or respiratory an	est,	Approximate
	Physician		Immediate/Cause (Final disease or condition Acutaly Perpose of Uncles			Interval Between Onset and Death 24 hours
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
h.	3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
8/60,	be ex sician a burial	icai E				
28	eath certificate be executed attending physician and for use as the burial-transit	77				
gox	ith cert tendin rr use	an/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	/ery
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	In the past 12 poinths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown 1 ☐ Unknown 1 ☐ Unknown 1 ☐ Unknown		Month	Day Year
	w requires that the de been signed by the should be detached			Part I. 23e. Did to	pacco use contribute to	the cause of death?
Suds	equire en sig ould bu	ted b	Cardishuyopethy, Atrice Fibrilahoy,	1 🗆 Y	es 2□No 3□Pro	bably 4 Unknown
ecc	e 2 sh	Completed by	Higherten Hoy	24a. Was a autops	v prior to c	opsy findings available ompletion of cause of
	sician: The lav certificate has rector, page 2	e Cor	OF Man ages referred to product	perfor	ned? death? ☑No 1☐Yes	21 No
<u> </u>	ysicia is cert directe	To Be	examiner?	Place of Death (Check only or Nursing Home 5 Reside		(6)
IO U	ing Ph		27. Manher of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day Year) 28b. Time of 1,000 Nork?	28d. Describe ho	w injury occurred	19)
VISION	death ctor: A y the fi	licati	2 Accident investigation M 1 Yes 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		and and More to the Co.	
2	al or A s after N Dira	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town	reet and Number or Rui i, State)	ai Houte Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certifica completely filled in by the funeral director,	edicai (29a Certifier 19 Certifying Physician: To the heat of my knowledge death	te and place, and due to the co	ause(s) and manner as	Stated.
	o the	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License num	ber 2	9d. Date signed /Mosth	Day Year!
	- 5 - 5		Budensheit HD RES-	-000	August 2	9 2004
	h		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			11 001
	<i>-</i>		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated. 29b. Signature and title of certifier 29c. License num PRES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CITANA BRADAUSKA ITE 14D Sinos for a signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature	cospetal of	130 thule	
	Stat Registra	100	SER 0.7 2004 Server & Souls			

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

SEP 0 7 2004

32. Registrar's Signature

death (Item 23a) (Type, Print)

OCME

SEPTEMBER 1, 2004

111 Penn Street, Baltimore, Maryland 21201

			. 101	partment of Health and Nertificate of Death	lental Hygie	_	28068
	Physici	an	1. Decedent's Name (First, Middle, Last)	OTHOREDO	2. Date of Death		3. Time of Death
	/Medic	al	FLORENCE	GINSBERG	2FL I FWRF	R ^{Day} 2, 2004	1:55 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) FUTURE CARE CHERRYWOOD	4b. City, Town, or Location of Death REISTER	STOWN	BALTI	MORF
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 1 F 87 Yrs.		8. Date of Birth MAY 8	9. Birtho	place (State or Foreign htry) MD
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	Ba-f sho	Director	110	STERSTOWN	17		1 ☐ Yes 2 🔀 No
	with the	Dire	10e. Street and Number 12020 REISTERSTOWN ROAD	10f. Zip Code 21136	100	g. Citizen of What Cour	USA
	death ma 23	nera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	can Indian,
920	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show the Modical Examinat must be notified at	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 ☑ No If Yes, 2 ive 2 ☑ Year or Dates:	1 ☐ Yes 2 🗖 No Specify:	rican, etc.)	Black, White,	WHITE
2-0	72 hc	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired)	ing 16	6b. Kind of Business/In	dustry
21215-0036	77	Completed	Flamentary/Secondary (0-12)	EMAKER		OWN HOM	1E
Maryland	b d la la	To Be C	17. Father's Name (First, Middle, Last) MORRIS HORY		e (First, Middle, Ma	aiden Sumame)	YAFFE
	d 2 sh th and 7 Is m traum			dling Address <i>(Street and Number or Rui</i> IRON HORSE LANE #			
Baltimore,	Pages 1 and nent of Healt int: If itam 2 iry or other	1 2	1 M Rurial 2 Cromotion 2 Pamoval from State cemetery, c	position (Name of rematory or other place) EISEN CEMETERY 9/2		oc. Location - City or To	
altin			`4 □ Donation 5 □ Other (Specify) ANSHE N 21. Signature of Funeral Service Progresse	22. Name and Address of Facility SO			
Ba	Departr Imports any inj		Aut The letter	8900 REISTERSTOWN			
	Observations		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arres	t,	Approximate Interval Between Onset and Death
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Ļ		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Classes of hijary that initiated events c.				
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due to	tated. o the cause(s)
	othe othe omple	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
	->-0		> Stephen Sicard	1028304		9/2/04	/
	X		30. Name and address of person who completed cause of death (Item 23a) (Type 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	thain St. Reis	to and the	MA	1136
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			Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
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	/Medic		4a. Facility Name (If not institution, give st	treet and number)	271	4b. City, Town, or			4c. County of Dea	
	Examin	er	Saint Joseph M		er	40. Oly, Tolli, or	Tows			timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs		9. Bi	rthplace (State or Foreign
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			Usual Residence of Decedent					11,00.0	11101111	77777
	ylan		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show fra Madical Examilian must be notified at	Funeral		Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (5	Specify Yes or No-	14. Race - Am Black, Whi	
ထွ	or its	呈	1 ☐ Never Married 🏂 Married	1 ☐ Yes 250 No If Yes, Give		I ☐ Yes 2∰ No	Specify:	to Tiloan, Ste.)		10, 010.
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no	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mothers Na	me (First, Middle, A		
3	ould Mer parke	70	LARL HO	DT JR			HUD	153	SEITER	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinating must be notified at anone.		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	and Number or R	ural Route Number,	City or Town, State,	Zip Code) 21093
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sic	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	one form our		Yes 2 □ No	291 Location (St.	rant and Number of F	Second Clause Alexander
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_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certific: completely filled in by the funeral director,		29a, Certifier 1 Certifying Phys	ician: To the best of my know	wiedge doct	occurred at the time	a data and nin-	and due to the	woolo) and many	a stated
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	0		20 Name and address of	mpleted cause of death (them	230) (Tuna	D3ØE	104			
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	Sta	te	FRANCIS KHOO M. 31. Date filed (Month), Pay, Weas)	D. 7601 09 32. Registrar's Signal		DRIVE T	rowson,	MARYLA	ND 21204	
	Registr		31. Date filed Ments, Cay, Year 2004	32. Registrar's Signal	19200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Registrar AMEND ITEM #1 PER PHY G835 Reg. No... 1. Decedent's Name (First, Middle, Last) 2 Date of Death CYNTHIA HOLTON -GARRIS Month Physician Year 20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner timere HMEVC MEdNE MUNUSA Martlevel ruta If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. Year Hours 1 M 200 Yrs. Director 213-68-3852 56 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int If Item 27 is marked other then "natural", or Items 23a or 28e-1 show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or Items 23a or 286-1 show traumatic event, the Modical Examinar must be notified at Completed by Funeral Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 3237 Normount IJ S A

14. Race - American Indian,
Black, White, etc. 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Sales Associate Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Linwood Holton Mae H. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae H. McDonald-Mother 3237 Normount Ave, Baltimore, Md 21216 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 🎇 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/4/04 Randallstown, Md 21. Signature of Fupe al Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MIMOVER disease or condition resulting in death) /Medical Due to (or as a cons squence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Year Month Day 4⊡Pregnant at time of death 5 Other (specify) been signed by the a should be detached i ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of eath 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date files (Mon

32. Registrar's Signature

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eral ctor		i. Social Security Number 216-09-7330 Javai Residence of Decedent	3. Sex 1 ☐ M 24 ☐ F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. Ma	Date of Birth (Month, Day, 1y 22,	Year) L912	9. Birthp Cour Ire	place (State or Fore http) =Land
To Day	1	10a. State 10b. County	Harford	10c. Ci	ty, Town or Lo		llsto	n			1	0d. Inside City Lin
be notif	Direct	10e. Street and Number 2808 Beechwood	Lane		-	10f. Zip Code	210	47	1	og. Citizen of		•
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State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #20b PER FH G9/07/94/if/jrate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** :12A M TOUBLER HOLMES 2,100 REN JAMIN /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 6-14-1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F 83 SOUTH CAROLINA 250-48-7001 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or Items 23a or 28a-f show 1 XYes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6824 BROMPTON RD. 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No BLACK Specify: f Yes, Give Year or Dates: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Heelin and Menlast Hygiene. Important: If ten 27 is marked other than 'natur any injury or other treumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -0-LABORER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIE RUSH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VANESSA HAWKES (GRANDDAUGHTER) 6824 BROMPTON RD. BALTIMORE. MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/07/2004 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEMORIAL PARK 9-3-2004 BALTIMORE, MARYLAND ` 4 ☐Donation Þ ☐ Other (Specify) 22. Name and Address of Facility SAILLY FUNERAL SERVICE VERNON BAILEY 21. Signature of Puneral Service Licens 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ernon 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPS10 **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner neurisma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death 1 Live birth Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à The law requires Ceval Freder page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed this certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check on one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of d 3 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person witho col EK -10 pay, Year) 32 Registrar's Signature 31. Date filed (Month, State 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** SEPTEMBER 05 54 Zocit Johnson Eulaine Treya /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number, Examiner MOSPITAL BALTIMORE, MARYLAND 21239 BALTIMURE CTOOD SAMARITAN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Oay, Y Sept. 28 9. Birthplace (State or Foreign Country) W. Virginia 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year 1 M 2 F Yrs 1924 79 Director 230-24-9570 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō U.S.A. 21205 5008 E. Biddle Street items 23a Completed by Funeral 72 hours after death 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🗓 No Specify: 3 √Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F is marked of 2 Μ. Burchett Tyler Erma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2400 Lincoln Ave. Baltimore, Maryland 21219 John E. Johnson (Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) September Department of Important: If it any injury or o 8,2004 Baltimore, Maryland Holly Hill 22. Name and Address of Facility 21. Signature of Foheral Seffvice L W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 marke. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA SPIRATION Sequentially list conditions, if any, leaving to inin ediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examine that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical IF FEMALE: Вох USE S 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Gaston Esophageal Reflex disess 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No CHROME OBSTRUCTIVE PULMONARY 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NILESH PATEL NO. RES 000 September 4,2006; 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BOULEVARD BALAMORE IND 21239 PATEL M.D. 5601 NILESH 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 7 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** inneak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE If Under 1 Year If Under 24 Hrs. Woodsing 201 MORF 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1001M 2□ F Birthplace (State or Foreign Country) **Funeral** Year) Months Days Min. Hours 215-16-989 Yrs Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "naturel", or Items 23e or 28a-f show 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE Completed by Funeral Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: white. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ORO hinnear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Department of Health a Importent: If item 27 Is eny injury or other tra BALTIMORE 3201 Woodring nordon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) acility BACTIMORE, IND 21234. 21. Signature of Funeral Service Lic ENANS FUNERAL CHAPTL, 8800 HARFORD RAD 23a. Part. Enter the disease, of complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Due to (or as a convequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Atter this certificate has been signed by funeral director, page 2 should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arter 3 Probably 4 □Unknown eux 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2**Ø**-No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 021022 -03-04 was Khalente 1115

Registrar

(MI) 21236

M. KonALbusk(MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOTE

32. Registrar's Signature

well

7672BERAIN

SEP 0 7 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Sept. 2004 **Physician** 2:45 a M Ann Marie Kaylor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) **Examiner** Westminster Carroll Lookabout Manor If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
De C. 5, 1930 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1□M 20 F 198-24-0098 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Hampstead Carroll Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2347 Utz Rd. South 21074 U.S.A. 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify. White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) liled within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker t of Health and Mental Hyur Item 27 is mark 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Vasco Joseph Monyok Letmit. Pages 1 and 2 sho.
Department of Health Primportant: If terrany injury Prime any injury Prime and In 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2347 Utz Rd. S. Hampstead, Md. 21074 Shawn Clark - daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State St. Bartholomew's Ch. Cem. Sept. 8,2004 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ckhardr Funeral 296 Charmil Dr. Chapel P.A. Manchester, Md. 21102 Eslando Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) nov unuler **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). iner the attending physician and hed for use as the burial-transit The death certificate be executed Exami and Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month Por in the past 12 menths?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) signed by the at P.O. 9☐ Unknown 9 Unknown 23e. Did topacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 1 No 1 Yes 21 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. Medical 29a. Certifier within 24 hor To the Fune completely f To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (It m 23a) (Type, Print) 30. Name and address of person wh 1125 Airport De KUZI Westminster MID 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

SFP 0 7 2004

ORIGINAL

			State of Maryla 1- State	and / Depar 3835 <i>Certi</i>	tment of Health	and Mental I h	Hygiene Reg. Ng	20 00 1	28076
	Physicia /Medic		Decedent's Name (First, Middle, Last) Roland B.		Miller		I 30	Year 2004	100
	Examin Funeral Director		215-28-5258 XX 2 0 F 72	CARE	Ab. City, Town, or Location BALTI If Under 1 Year If Und Months Days Hours	MORE er 24 Hrs. 18 Date of		9. Birtt	nplace (State or Foreign untry) MD
	death with the Maryland ms 23a of 28a-f show f mast be notified at	Director		City, Town or Loca			10g. C	itizen of What Co	10d. Inside City Limits 1 ☐ Yes XXNo untry?
30		by Funeral D	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	_	21228 as Decedent of Hispanic (res. specify Cuban, Mexic res. 27 No Specify Cuban		r No-	U.S.A 14. Race - Ame Black, White Specify:	rican Indian,
71213-00	d withi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade na	(Give kir lite. DC	nt's Usual Occupation nd of work done during m O NOT use retired) Equipment	Operato	c Cit	Kind of Business/	Industry
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aitimore, iv	nit. Pages 1 and ariment of Health ortent: If item 27 injury or other ti		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) M	b. Place of Disposit cemetery, crema D Nation	tion (Name of tory or other place) nal Cemete	9/04/04 ry 9/5/0	20c. L	ocation - City or	
Da Da	permit Depar Impor any in		23a Part : Enter the disease, or complications that caused the chock, or heart failure. List only one cause on each line.	Ma 43	Name and Address of Fac arch F H W 300 Wabash the mode of dying, such	est Ave, Ba		ore, Md	21215 Approximate Interval Between Onset and Death
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Immediate Cause (Final disease) a. Due to (or as a condition of the	0=11	I FAILU AL FAIL	URE URE			26 M2N unknown
8/60,	cate be executed oblysician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Oue to (or as a conditions) to the cause (Disease or injury that initiated events resulting in death) Last c. FPTI Due to (or as a conditions)	C St	10CK				unknown
r.c. Box b	death certific e attending p ed for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of production of the past 12 months? 4 Pregnant at time 9 Unknown	Fetal déath 3 □E	ectopic pregnancy Other (specify)		_	23d. Date of deli Month	very Day Year
	The law requires that the te has been signed by th iage 2 should be detache	by	Part II. Other significant conditions contributing to death but not CHRONIC OBSTRUCTIVE PULL	resulting in the und	, , ,	WERBATION	1 ☐ Yes 2	2 □ No 3 □ Pro	
Vital Records,		Be Completed	ANAEMIA OF CHRON	VIC DI				death?	topsy findings available completion of cause of
DIVISION OF V	Phys this ral di	ertification; To	1 Yes 2 Tho Hospital: 1 Inpatient 27. Manner of Death 1 Matural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be		28c. Injury at Work? M 1 ☐ Yes 2	□No	ribe how inji	ury occurred	oify) aral Route Number,
2	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Certif	4 Homicide determined building, etc. (St	pecify) knowledge, death o	occurred at the time, date	City o	r Town, Sta	te) s) and manner as	stated.
	To the within 2 To the Comple	Med	29b. Signature and title of certifier Sun MD		29c. License number			ate signed (Month	n, Day, Year)
	Oth Sta		30. Name and address of person who completed cause of death Y I SUN: SAINT ABNES 31. Date filed (Month, Day, Year) 62. Registrar's S	HEALTH	rint) I CARE, 9	00 CATOI	VAV	E, BALTI	MORE, 21229
	Regist	ar	SET V (2004)	U. ASSA					

Chartes #111am Numerlyn September 3, 2004 #8;15pm Chartes #111am Numerlyn September 3, 2004 #8;15pm Chartes #111am Numerlyn September 3, 2004 #8;15pm Casey House Hospital Committee Formula Director Dir				For State Registrar	State of N	Maryland / De	oartment of I e <i>rtificate of</i>			giene	4 28077
Charles William Munerlyn September 3, 2004 811ppn Gasey House Hospice		Dhysiai	20	1. Decedent's Name (First, Middle	e, Last)			,			
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A	ary	shou and M mar umat	-	19a. Informant's Name/Relations	hip (Type, Print)	19b. Ma	iling Address (Stree	t and Number o	r Rural Route Numbe	r, City or Town, S	State, Zip Code)
A		and 2 paith a n 27 ls		Doris Munnerly	yn (Wife)	1600	l Dorset 1	Road, La	urel, Ma	ryland 2	20707
23. Part. Efter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (final results) in class of near flative. List only one cause on each into cause on ea	ore	of He			3 □Removal from Sta	comotoni a	position (Name of rematory or other pla	ace)	Date	20c. Location - 0	City or Town, State
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State Congestive Heart Failure State St	Ball	Departing Departing Important in processing		21. Signature Fune al Service	/ /WV)	01250	22. Name and Addr 7601 Sand	ess of Facility Spring	Fleck Fun Road, L	eral Hom aurel, M	ne, Inc. Maryland 20707
Congestive Heart Failure Due to (or as a consequence of): Due to (or as a conseq	П			shock, or heart failure. List	complications that cause only one cause on each	sed the death. Do not on line.	enter the mode of dy	ing, such as car	diac or respiratory ar	rest,	Interval Between
Due to (or as a consequence of): FEMALE 30. Was deceded pregnant in the past 12 months? 1 Yes 2 No 1 Yes 2 No 235. Was case referreg to medical examination and/or investigation. In the best of many and examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 247 10 10 10 10 10 10 10 1				disease or condition	a		rt Failure	2			
State						- Diacon				A3500 X W SC	
The second property of the standard events of the standard of the standard e			-	Sequentially list conditions, if any, leading to immediate			Disease				ropene
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FFEMALE: 230. Was deceded pregnant in the past 12 months? 1 1 4 5 5 6 6 7	oʻ	e exer ian ar urial-t		resulting in death) Last	Due to (or	as a consequence of):					
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26. Place of Death (Check only one) 27. Mann of Death 1 Yes 2 No 28. Describe how injury occurred 28	<u>=</u>		Con							med? de	eath? ☐ Yes 2☐ No
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Vother (Specify) Hospice 27. Manny of Death 1 Vatural 2 Accident 3 Suicide 4 Homicide 4 Homicide 28. Date of Injury 4 Determined 5 Pending investigation 6 Could not be determined 28. Place of Injury - At home, farm, street, factory, office 28. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD 10400 Connecticut Ave., Kensington, Maryland 20895 State 3 DOA 4 Nursing Home 5 Residence 6 Vother (Specify) Hospice 4 Nursing Home 5 Residence 6 Vother (Specify) Hospice 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Describe how injury occurred Work? 1 Pyes 2 No 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD 10400 Connecticut Ave., Kensington, Maryland 20895	Vita	ician Sertific ector	00	examiner?	Hospital						
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD 10400 Connecticut Ave., Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature	On	nding th. : Afte s fune	tion	1 Matural 5 ☐ Pendir	'9	Day Year) Injur	y W				
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Eugene P. Libre, MD 10400 Connecticut Ave., Kensington, Maryland 20895 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		X		· ct	tike	MD.		D09470		Septemb	er 4, 2004
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Jo.			•			. Kene	ington. Ma	arvland	20895
/ / / EM/IM/A//				31. Date filed (Month, Day, Year,	32. Regi	istrar's Signature	1	., Kens	ingeon, n	ar y rana	200,0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 06:17 PM **Physician** WADIE F MALEK AUGUST 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner NOT APPLICABLE BALTIMORE, MD SHOCK TRAUMIA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 18 M 2□ F Director 87 03/02/1917 Egypt 071-62-9796 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County injury or other traumatic event, the Medical Exame at must be multiped at 1 Yes 2 □ No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 524 N. Charles Street 21201 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 240 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 naturel', or Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Management Oil Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Farid Malek Bahia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9504 Timberlog Drive Chattanooga, Tn 37421 Nabil Malek 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. Wash. Crematory 8/31/2004 Baltimore, Maryland ^¹ 4 □ Donation 21. Signaturn of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician SUBACHCHNOID HEMORRHAGE 29 resulting in death) /Medical Due to (or as a consequence of): Examiner 29 SYNCOPE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed STENOSIS AORTIC for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 ₽No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending Injury FALL FROM TRAIN 3: 10 1 ☐ Yes 2 ☑ No death. investigation 2 Accident AUGUST 1,2004 after death Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide LIGHT RAIL STATION 450 CAMP MEADE ROAD To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD AU4176435-16113 AUGUST 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE STREET, BALTIMORE, MD CHRISTOPHER YOU, 22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1- For State of Maryland / Depart Registrer Certific	ment of Health and Microsite of Death	, ,	2001	20070
			Registrar 1. Decedent's Name (First, Middle, Last)	icale of Dealif	Reg. 2. Date of Death	No. UU	3. Time of Death
	Physici	an		27 1-	Month	Day Year	
	/Medi		Harold	Nash	ANY 2	7	5:05PM
	Examir	ner		b. City, Town, or Location of Death		4c. County of Death	
			I.evindale Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	Baltimore Under 1 Year If Under 24 Hrs.	8 Date of Birth	Q Right	place (State or Foreign
	Funeral Director		1₽M 2□F Vcc M	Ionths Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign htry) A
			192-12-4548 X 82 Yrs. Usual Residence of Decedent		06 11	22 1	A
	/land		10a. State 10b. County 10c. City, Town or Locati	ion		1	0d. Inside City Limits
	Mar	to	MD NA Baltimore	i i			XXYes 2 □ No
	r 288	rec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	h with	by Funeral Director	820 South Caton Ave Apt 4F	21229		U.S.A.	
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Americ	
9	or Ite	Ē	1 □ Never Married 2 ☑ Married 1 □ ☑ Yes 2 □ No If Yes, Give 1 □	Yes 2 No Specify:	rican, etc.)	Black, White,	etc.
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Medical Examinet himilad at	l by	3 Widowed 4 Divorced Year or Dates:	res z <u>ia</u> No specify.		Specify:	Black
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Maryland	01 00 00			ddress (Street and Number or Rura			
	1 and 2 Health Iem 27 I	1 3		outh Caton Ave	_		
ore	Pages 1 nent of H int: If ite		XXBurial 2 Cremation 3 Removal from State	ory or other place)		. Location - City or To	own, State
Ë	Pa ant ury			Hill 9/3/0	04 G]	en Burni	le, Md
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility ch F/H West			
	₹0 = # 0		1 John 1 Waren 430	O Wabash Ave,		ore, Md	21215
г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Pnysician	6	Immediate Cause (Final disease or condition	d Injury	MINER		Onset and Death
	/Medical		resulting in death) Due to (or as consequence of):	00	CAL M		74.5
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	and and trans	am	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	THE WILL			
30,	ate be executed sysician and he burial-transit		Due to (or as a consequence of):	CERTIFY 1			
8760	at by	dical	d				
9 ×	leath certific attending pl	Physician/Med	IF FEMALE:				
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	topic pregnancy		23d. Date of delive Month	ory Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Ot 9 ☐ Unknown	her (specify)			,
Θ.	that the dead by the detached	Ph	Part II. Other significant conditions contributing to death but not resulting in the unde	shing appearance in Doct I	22a Did tobass	o use contribute to the	a sever of death?
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ec	e law has b ge 2 sl	nple	End Stage Renel Diseas	26	24a. Was an autopsy	prior to cor	psy findings available npletion of cause of
_		Co	HTN		performed		2 🗆 No
Vital	ding Physicien: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of \	Physi this c al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			6 □Other (Specify	1)
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Division	Attending r death. ector: After by the fune	Certification;	25 Accident investigation June 20 2001 Unknown		ell dow	n step	5
Ξ	I or Attendated death Director:	Ē	4 Homicide 28e. Place of Injury - At home, farm, street, building, etc., (Specify)	factory, office 2	8f. Location (Street City or Town, St	and Number or Rira	Route Number Ho
	ital curs af		Church	6	toly gho		MD were
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death oc (Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation).	curred at the time, date and place, a ligation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
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7			J mo	056508	in	ng 30	cvy
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type, Prir	056508 NE BRITIME	SHA	6	. +~
	ş		2434 W Belvedore Un	re, Ballim	ore,	MD ZIZ	N
	Sta		31. Date filed (Month, Day, Year) SEP 0 7 2004	South)			
	Regist	rar	DEL O L'EUR PARENTE	And have			

			1 - For State Registrer	e of Maryland /	-	rtment tificate			ind M	R	eg. No. 0	04	28080
	Physici		Decedent's Name (First, Middle, Last) LILLIAN	NU	GER-	BERGE	3			2. Date of Dea Month	Day	Yeer 2004	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give street and LEVINDALE HEBREW HOME	i number)		,	own, or	Location o	f Death		4c. Coun	ty of Death	N/A
	Funeral Director		5. Social Security Number 6. Sex $215-28-2948$	F 7. Age (In yrs. last to	oirthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Month Day APR. 15	1 9 30	9. Birthp Cour	place (State or Foreign MD
	yland how		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To								1	0d. Inside City Limits
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5-0036	after or Ite	by Funeral Director	Ame 1 Never Married 2 Married 1 1	Decedent Ever in U.S. d Forces? (es 2 M No s, Give or Dates:	1	Vas Decede f Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Americ ack, White, ify:	
21215-0	swithin 72 hours piene. r than "naturel", it e Madical Ext	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) 5+	ted)	(Give	lent's Usual kind of work DO NOT use ER	done di	uring most	of worki	ing	16b. Kind of I	Business/In	
Maryland 2	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other treumatic event, Item	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN	SH	APIR	0		18. Mother		(First, Middle,	Maiden Suma		SENBLOOM
Mary	5430		19a. Informant's Name/Relationship (Type, Print, MARC NUGER / SON							I Route Number			
Baltimore,	permit. Pages 1 am Department of Heali Importent: If Item 2 any Injury or other once.		20a. Method of Disposition 1 🛱 Burial 2 Cremation 3 Removal f 4 Donation 5 Other (Specify)	20b. Place cemei	of Dispo	sition (Name	e of her place)	C		20c. Location		wn, State
Balti	permit. Departm Importer any Inju		21. Signature of Funeral Service Licensee		22	. Name and	Address	s of Facility	y S01	LEVINS	SON & B	ROS.,	-
	Pnysician /Medical		resulting in death)	hat caused the death. Do on each line.	e	Rena					est,		Approximate Interval Between Onset and Death
8760, €	eate be executed thysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events c.	e to (or as a consequenc	e of):								
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rds, P	requires that the de een signed by the a nould be detached t		Part II. Other significant conditions contributing	to death but not resulting			use give	n in Part I.		23e. Did tol	• •		ne cause of death? ably 4 □Unknown
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ion of	fter	-	27. Manner of Death 28a. I		. Time of Injury		c. Injury Work	4 🗀 1901		28d. Describe ho			//
Division	el or Atte s after des il Directo	Certification;	3 TSuicide 6 Could not be 4 Homicide 28e. F	Place of Injury - At home, building, etc. (Specity)	farm, str	eet, factory.	office			28f. Location (St City or Town		ber or Rura	I Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 X Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowled he basis of examination a manner stated.	ge, death and/or inv	occurred a restigation, i	t the time in my op	e, date and inion, deat	d place, a	and due to the cased at the time, d	ause(s) and mate and place	nanner as si	ated. the cause(s)
	To t To ti	M	29b. Signature and title of certifier	7			License	(50	P		9d. Date sign	ed (Month,	Day, Year)
	15		30. Name and address of person who completed 2B4 W Belvede		(Type,		LIA	NGR	cove	MD Z	ino 2/215		. 200/
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 7 2004	32. Registrar's Signature	A	bout							-

			1 - For Stete Registrer	tate of Maryla		artment of H		nd Mental Hy	giene	01	00001
			Decedent's Name (First, Middle, Last)	1				2. Date of D	eath	U 	3. Time of Death
r	Physici		Beatrice F	oterk	in			(EP	T Day	A OO4	11:00D M
	/Medic Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of		4c. Cour	nty of Death	1
Н	XGIIIII		Bon Secours			Baltimore				NA	
	Funeral		Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bi	rth	9. Birthp	lace (State or Foreign
	Director		216-28-6238 1□ M	² 2 78	Yrs.	Months Days	Hours	Min. 09–22–19	av. ^{Year)}	South	Carolina
	P		Usual Residence of Decedent								
	nylar	_	10a. State 10b. County	10c. (City, Town or Lo	cation				10	Od. Inside City Limits
	8a-1 8	cto	MD NA		В	altimore					1X()Yes 2 □ No
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	23a	Funeral Director	1510 W. Mosher Street Apt	5J		212	217		USA		
	r deg	lue I		Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origi n. Mexican.	in? (Specify Yes or No Puerto Rican, etc.)	o- 14. R	lace - America	
9	or It	Ĭ,		1 ∐Yes 2 X No If Y <i>e</i> s, Give	j	1 ☐ Yes 2 🕱 No	Specify:	,			
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auc	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23e or 28e-f ahow atto event, the Medical Evarth at most be notified at	Be	The date of table (First, Missie, Elist) (III)	.IOWII				es Peterkin	, Maldell Sulfi	ame)	
Maryland 21215-0036	should ind Men a marke umatic	5	19a. Informant's Name/Relationship (Type,	Print)	10h Mailin	an Address (Street a		or Rural Route Numb	or City or Tour	- Chaha Zia	C- d-)
Ma	d 2 s th an 7 la i traui		Kaiser Peterkin/ Brother	Filing				Baltimore,			Code)
	1 and Health em 27 thar tr		20a. Method of Disposition	20b	. Place of Dispos		1	Date		n - City or To	wn State
õ	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	cemetery, cren	natory or other place	·			,	Wii, Otato
Baltimore,	it. Partmel		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	we		r Cemetery	1	9-08-04	Catonsvi	iie, MD	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Evanties must be notified at once.		21. Signature of Funeral Service Licensee		,	. Name and Addres	,	e 638 N. Gilm	or Stree	t Ralto	MD 21217
			22a Part 1 Sator the disease or compliant	and that accord the de						t marco,	
ŀ			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ause on each line.	ath. Do not ente	er the mode or dying	g, such as ca	And ac or respiratory a	irrest,	4	Approximate Interval Between Onset and Death
	Physician	4 1	Immediate Cause (Final disease or condition resulting in death)	WHSSIU	e ce	re Ord	UOS C	ulor acc	1 den	T	
	/Medical Examiner		rossing in dodain	Due to (or as a cons	equence of):	Λ Λ			,		
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687	phys the	dical	d								
ox e	eath certific attending p	by Physician/Me	IF FEMALE: 23c	If yes, outcome of pred	nancy				004.5	2-46 -4-15	
Bo	atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
o	he de	ysk		9☐ Unknown	I dea(II J	Ciriei (specily)					
ď.	uires that the de signed by the a id be detached f	' Ph	Part . Other significant conditions contrib	uting to death but not r	esulting in the ur	iderlying cause give	en in Part I.	23e. Did	tobacco use co	intribute to th	e cause of death?
Records,	sign d be					, ,			Yes 2□No		1
Ö	w requir been si should	ete									
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	Phys this aldi	. To	TE TOS ZENIO	1 Inpatient 2	☐ ER/Outpatient 28b. Time of	t 3 DOA 28c. Injury	4 🗌 Nurs	sing Home 5 Resi)
L C	Attanding Physician: or death. ector: After this certific by the funeral director,	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	rat (? Yes 2.⊟No		how injury occi	TUBO	
S	uttandi death. ctor: A y the fu	ical	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At	home farm stre		193 5 140		Street and Num	nhor or Bural	Route Number.
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	pital ours inled		29a. Certifier 1 Certifying Physicia	an: To the best of my k	nowledge death	accurred at the tim	o dato and	place and due to the	onune(a) and s		
	24 h 24 h e Fur etely	Medical	(Check only 2 Medical Examiner: one)	On the basis of examinand manner stated.	nation and/or inv	estigation, in my op	pinion, death	occurred at the time,	date and place	and due to	the cause(s)
	To the Hospital or within 24 hours afte To the Funeral Direction Completely filled in It	Me	29b. Signature and title of certifier	1	Λ	29c. License	number		29d. Date sign	ned (Month, E	Day, Year)
	⊢ s ⊢ ō		* MARINER -	1 Ann	nlong	NZ	772	03	Sont	2	2014
/			30. Name and address of person who, compl	eted cause of death (It	em 23a) (Type 1	Print)	10	V	7	· 0	VW.
5			O. TON CR	1 Ams N	1 12 (1ype, 1	BON SO	Cours	Hornota	V. Br	Otimo	TO MO
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature /	1	C 0 0 1 -	2	400	<u></u>	10 11-04
	Registr		SEP 07 2004	Some	DO)	Sports					

Datient Known As Herman Robinson

					Mental Hygien	e	28082
ical iner	5. Social Security Number 5. Sex 7922	O.F Baltimo	last birthday) If Und	altimore C er 1 Year If Under 24 Hrs	September 1 h ity 8. Date of Birth	C. County of Death	3. Time of Death 0.6 37 A M NIA Dlace (State of Foreign
To Be Completed by Funeral Director	10a. State 10b. County 10e. Street and Number 3608 Lynchestel 11. Marital Status 1 Never Married Married 3 Widowed Divorced 15. Decedent's Educ (Specify only highest grade) [Sempetary/Sepondary (0-12) Philosophy (1-12) Philosop	2. Was Decedent Ever in U Armed Facces? 1 Yes 25 No If Yes, Give Year or Dates: ation completed) 1 Callege (1-4or 5+) 2 SR. 6 Intt Armod Facces? 1 Yes 25 No If Yes, Give Year or Dates: ation completed) 2 Callege (1-4or 5+) 3 Callege (1-4or 5+) 4 Callege (1-4or 5+) 4 Callege (1-4or 5+) 5 Callege (1	In the second of	dip Code 2125 Bedent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 22 No Specify: 22 No Specify: Bual Occupation work done during most of wouse retired) 18. Mother's Name of Street and Number of other place) and Address of Facility	Specify Yes or Noto Rican, etc.) The Rican, etc.) The Royal Middle, Maide Control Co	14. Race - Americ Black, White, Specify: Black, White, Specify: CONSPORT TOWN, State, Zip Consolon - City or Town, State, Zip Consolon - C	can Indian, etc. ACK dustry Tation Code) 21215
cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of pregnature) Due to (or as a consequence of pregnature)	juence of): juence of): juence of): ancy	`\	c or respiratory arrest,	23d. Date of deliv	Approximate Interval Between Onset and Death I YEAR 5 YEARS
	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con Chronic Obstruence Chronic Obstru	4☐ Pregnant at time of ce education of the education of	death 5 Other (cause given in Part I.	1 Yes 24a. Was an autopsy performed?	2 No 3 Prot	~ /
Certification: To B	examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Special	28b. Time of Injury M ome, farm, street, fact fy)	OOA Other: 4 Nursing N	dome 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	ury occurred and Number or Rura te)	al Route Number,
Medica	29b. Signature and title of certifier 20b. Additional address of person who co	er: On the pasis of examina and manner stated. Miles and manner stated.	m 23a) (Type, Print)	9c. License number PLS - 000	29d. D	ate signed (Month,	Day, Year)
	Medical Certification: To Be Completed by Physician/Medical Examiner To Be Completed by	Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Modernia Sease or injury that initiated events resulting in death) Sequentially list conditions on the past 12 months? 1988 2 Modernia Sease or injury that initiated events resulting in death) Sequentially list conditions on the past 12 months? 1988 2 Modernia Sease or injury that initiated events resulting in death) Sequentially list conditions on the past 12 months? 1988 2 Modernia Sease or injury that initiated events resulting in the past 12 months? 1988 2	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Social Security Number 3. Social S	State of Maryland / Department Registries 1. Decodent's Name (First, Middie, Last) 4. Falliny Name (First, Middie, Last) 5. Social Security Number 4. Falliny Name (First, Middie, Last) 5. Social Security Number 4. Falliny Name (First, Middie, Last) 1. Social Security Number	State of Maryland Department of Health and Per In C33 Department	State of Manyland Department of Health and Mental Hygien Reput Programment of Programment of State of Debts Reput Programment of Programment	Source Security Number Size Siz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month September 2, 2004 **Physician** 1:30 am RUPPEL CAROLYN MARIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Anne Arundel 3502 River Bridge Way | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | 9. Birthplace (State or Foreign Months Days Hours Min. Oct. 10, 1946 | Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F 57 Yrs 213-46-9184 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examinat must be notified at 1 Yes 2 No Director Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. 239 3502 River Bridge Way 20724 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes À No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes XX No Specify: Specify: Completed by 3 XXidowed 4 ☐ Divorced White "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Duron Paints Asst. Manager/Accounting permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other It any injury or other traumetic event, Ita once. Grade 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Ferguson Henry John Klimek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8716 Granite Lane Laurel, Maryland 20708 Mary Ann Fell sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/08/2004 `4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, 21. Signature of Funeral Service Licensee / M00770 Laurel, Maryland > 20707 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fallopian Tube Carcinoma Years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 5 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 XXo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed: 1 Yes 2 Tho 1 ☐ Yes 2XXN0 certificate Vital Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕅 🛪 esidence 6 ☐ Other (Specify) 1 ☐ Yes 2 🟋 🎌 2 After this Division of Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1 XXxtural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a 29a. Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the I 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number D 45014 September 2, 2004 Joelell 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella Martire, M.D. 8343 Cherry Lane Laurel, Maryland 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

SEP 0 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

				1- State of M	arylan	-	artment of F rtificate of	lealth and M <i>Death</i>	lental Hygie Reg	2001	28021
				Decedent's Name (First, Middle, Last)					2. Date of Death	how the same of th	3. Time of Death
		Physici /Medic		Andrew George	Smi	th			Septembe	$r^{\text{Day}}2$, 2004	3:52 A M
		Examin		4a. Facility Name (If not institution, give street and number)			1	r Location of Death		4c. County of Death	
				Joseph Richey Hospice 5. Social Security Number 6. Sex 7. Ag	e (In vrs.	last birthday)	If Under 1 Year	Baltimore If Under 24 Hrs.	8. Date of Birth	N/ 9. Birth	
		Funeral Director		173-09-8707 1X M 2□F	86	Yrs.	Months Days	Hours Min.	(Month, Day, Y	1918 Penn	place (State or Foreign Intry) SYlvania
		p ,		Usual Residence of Decedent 10a, State 10b, County	10c Cit	ty, Town or Lo	nostion				10d, Inside City Limits
		Aaryla F shov	ō	Maryland Howard	100. 010	y, rown or E	Ellicot	t City			1 ☐ Yes 2 X No
		28e-	rect	10e. Street and Number			10f. Zip Code	L CILY	10g	. Citizen of What Cou	untry?
		23a o	al D	4025 Font Hill Drive			2104	12		USA	
		r dea	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces:	Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
	36	rs afte	by Fi	1 ☐ Never Married 2 ⚠ Married 1 ☐ № s 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	No		1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
	21215-0036	2 hou		15. Decedent's Education	1712		dent's Usual Occup	pation during most of works d)	16	b. Kind of Business/Ir	ndustry
	218	ithin 7 18. 18. "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)				ing	TT	_
	121	iled w Tygier ther th		17. Father's Name (First, Middle, Last)		Micro	biologis		e (First, Middle, Ma	University	y
	Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene, ie marked other then "naturel", or iteme 23a or 28e-f show reumatic event, the Medical Examinat must be notified at	To Be	James Henry Smith					e Gerrits		
	ary	and M e mar	-	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street			City or Town, State, Zi	p Code)
	2	and 2 ealth m 27 i		Lucy E. Smith/Wife	201 5					ity, MD 21	
7) OF	ages 1 to the street or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State		cemetery, cre	osition (Name of matory or other pla	Inc. 9/3/		c. Location - City or T	
10	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 ie marked other then "naturel; or iteme 23a or 28e-f show any injury or other treumatic event, the Madical Examinat must be notified at ance.		`4 □Donation 5 □ Other (Specify) 21. Signature 5 □ oracl □ eryige Ligensee	riet					Baltimore,	MD
18	B	Depar Depar Impor any ir		Edward A. Gregorchik		2	remation 99 Freder	Society cick Road	Baltimore	e, MD 2122	8
5				23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the deat		ter the mode of dyli	ng, such as cardiac			Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)	Oly	ner	5 115	lase			Onset and Death
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45	8760,	icate be executed physician and s the burial-transit	al Ey	resulting in death) Last Due to (or as	a conseq	(uence or):					
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	O. B	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  in the past 12 months?  4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)			Month	Day Year
7	Ρ.	that the ed by th detache		Part II. Other-significant conditions contributing to death	but not res	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
1	rds	requires leen sign hould be	ed by	YJYKINGONS					1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
7	ecor	law recast beg	plete	/ / /					24a. Was an autopsy	A prior to co	opsy findings available ompletion of cause of
()	$\alpha$	The late has page	Completed	//					performe	d? death?	/_
~	Vital	Physicien: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? Hospital:			0#	nor:	h (Check only one)		thouse
7	of		To	27. Manner of Death 28a. Date of Inj	ury	ER/Outpatie 28b. Time of	II 3 DOA	4 □ Nursing Ho	me 5 Residence 28d. Describe how		MUSICA
2	ion	Attending F r death. sctor; After by the funer	ation	1 Natural 5 ☐ Pending (Month, Di 2 ☐ Accident investigation	ly Year)	Injury		rk? Yes 2 □No			
7	Division	or Atterdenter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could no be 4 ☐ Homicide determined 28e. Place of In- building, e	ijury - At h	ome, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
7	Q	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the		29a. Certifier 1 Certifying Physician: To the best	t of my kny	owledge deal	h occurred at the ti	me date and place	and due to the caus	so(s) and manner as	etatod
A		e Hos 24 ho e Fun letely	Medical	(Check only one)  2 Medical Examiner: On the basis one)  and manner s	of examina	ation and/or in	vestigation, in my	opinion, death occur	red at the time, date	and place, and due t	o the cause(s)
_		To the within 2 To the complet	Me	29b. Signature and title of certifier)	7		29c. Licens	se number	29d	. Date signed (Month)	Day, Year)
				IVIUN MUME MI	/		113	5012	,	1/2/0	4
		ITIVA		30. me nd address of person o completed cause of	de th ter	m 2 7) (Type	Print)	For B	2/4mil	m / May	2/2/14
			ate [.]		tror's Signa	ature		11 400	11 / F. / F.	1	
		Regist	rar	SEP 0 7 2004 ▶ A	10.0	Lo	1				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 3, 2004 **Physician** MARY ELLA SISSON 5:10 a M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11451 Harding Road Laurel Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F 220-07-1407 88 Yrs. Ĭ916 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Howard Laurel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11451 Harding Road 20723 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed. Grade 12 College (1-4or 5+) Special Clerk Telephone Company other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked off Millard M. Murphy Mary Emma Dustin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Susan Tinetti daughter 11457 Harding Road Laurel, Maryland 20723 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5 permit. Page Department o Important: If any injury or once. Emmanuel Church Cem 09/07/2004 Scaggsville, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 4 -/M00770UZ 313 Talbott Avenue Laurel, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Pleural Effusion Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypothyroidism, Dyslipidemia Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Degenerative disk disease autopsy performed? certificate 1 Yes 2 X X 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 💥 🕶 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one) Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signar re and title of certifier D 50184 September 3, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9501 Old Annapolis Road #205 Zhanna M. Kalikhman, M.D. Ellicott City, Md. 21042 31. Date filed (Month, Day, Year) SEP 0 7 20 32. Registrar's Signature State 0 7 2004 Sparker

DHMH 17 Rev 1/2001

Registrar

			for 1_ State	State of Marylar	nd / Department of Health and	Mental Hygien	e
		_	Registrar		Certificate of Death	Reg. No.	
	Physici	an	1. Decedent's Name (First, Middle, L	G Sta-	ffone	Month Death	ay Yeem Q M M
	/Medic Examin		4a. Fecility Name (If not institution, gi		4b. City, Town, or Location of Dea	th 4	c. County of Death
	CXAIIIII	lei	Manor Car	20 Rusto	n TOWSON	J	BALTIMORE
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	Months Days Hours Mir		9. Birthplace (State or Foreign Country)
~	Director		Usual Residence of Decedent	100 M 2□F S	13 Yrs. Months Days Hours Mir	6-6-21	NEW YORK
	land ow		10a. State 10b. County	10c. C	ity, Town or Location		10d. Inside City Limits
	Mary e-f eh	tor	MD BALTI	MORE	Timonium		1 ☐ Yes 2 No
	or 28	Funeral Director	10e. Street and Number	. 04	10f. Zip Code	10g. C	itizen of What Country?
	ath w	ral	2004 Dumoi	it pa.	21093.		USH
	er de	nne	11. Marital Status 1 □ Never Married 2 Marned	12. Was Decedent Ever in U Armed Forces? 1 10 Yes 2 ☐ No	J.S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
336	urs aft	by F	1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	If res, Give Year or Dates:	1 ☐ Yes 2 I No Specify:		specify: White.
5-0036	72 hours after death with the Maryland naturel', or iteme 23a or 28e-f ehow dreal Exanghet must be notified at	Completed by	15. Decedent's E	Education	16a. Decedent's Usual Occupation	16b. I	Kind of Business/Industry
21	within iene. then i	nple	Elementary/Secondary (0-12)	College (1-Aor 5+)	(Give kind of work done during most of we life. DO NOT use retired)	alouted to	- Land Course &
121	filed w Hygiei other ti		17. Father's Name (First, Middle, Las	1)	Financial Hamini	STORTOK TE	aderal Covernment
and	Mental I Merked of arked of	To Be	Torach S	Staffon	March	Reidoct	- Pollutro
Maryland	2 should and Men is marke eumatic	ř	19a. Informant's N me/Relationship	(Type, Print)	19b. Mailing Address (Street and Number of F	Pural Route Number, City	10110
Ž	1 and 2 Health a em 27 lg		Doris Staffo	ne-wife	2004 Dunion+ Po	L. BALTIM	DRE MD 21093
ore	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	Place of Disposition (Name of cometery crematory ar other place)	Date 20c. L	ocation - City or Town, State
Baltimore	Pag tment tent: jury c		*4 □Donation 5 □ Other (Spec	EV.	ANSFUNGEALCHAPEL- 9-		Rest Hill MID
Bai	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Lie	ensee	22. Name and Address of Facility		110m mD 21093.
13			23a. Part1. Enter the disease, of cor	npications that caused the dea	th. Do not enter the mode of dying, such as cardia		DERAL & CREMATIONS Approximate
9	Dhysisian		shock, or heart failure. List ont	one cause on each line.	Artery Disease		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	71110101		
	Examiner		Sequentially list conditions	b			
	De iii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doe to (or as a conse	guence of).		
	and I-trans	xam	that initiated events resulting in death) Last	c. Due to (or as a conse	Tuence of):		
8760,	cate be executed obysician and the burial-transit	icalE		d	7		
9	ificate g phy: as the			d			
Вох	leath certifica attending ph for use as th	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn			23d. Date of delivery
	e deal he att	Physician/Med	in the past 12 months?	4☐Pregnant at time of e			Month Day Year
P.0	hat the		9 Unknown	contributing to death but not re-	sulting in the underlying cause given in Part I.	23e Did tobacco	use contribute to the cause of death?
ecords,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	d by	7 arm substantial	contributing to doubt but not re-	salang in the discenying cause given in Fait.	1 ☐ Yes 2	
Sor	w requ	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lay ate has page 2	duic				autopsy performed?	prior to completion of cause of death?
ta	en: T tificat tor, pa	Be Co	25. Was case referred to medical		26 Place of De	ath (Check only one)	1 Yes 200 No
of Vital	Physiclen: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	Other:	Home 5 Residence	6 ☐Other (Specify)
0 0			27. Man⊓ar of Death 1 Watural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work?	28d. Describe how inju	ry occurred
sio	Attending ir death.	catl	2 Accident investigation 3 Suicide 6 Could not	ne -	M 1 ☐ Yes 2 ☐ No		
Division	or At after of Direct in by	Certification:	4 Homicide determine	building, etc. (Speci	nome, farm, street, factory, office fy)	281. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	spitel nours nerel		29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge, death occurred at the time, date and place	e, and due to the cause(s	and manner as stated.
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	ation and/or investigation, in my opinion, death occ	urred at the time, date an	d place, and due to the cause(s)
	To the Comp	W	29b. Signature and title of certifier	1	29c. License number	29d. De	ate signed (Month, Day, Year)
	/(			1	CENO 17 000479	7 91	404
	NX1		30 Name and address of perso who	completed cause of death (Ite	m 23a) (Type, Print)	monium 1	MD 21093
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	11/01/1007	- 13 010 1-
	Regist		CED 0 7 2004	Bern b. At	Annal 1		

		1	State Amend Ite	State of Mary an 26 per Ver	land / Dep <b>b.,G835</b> 6	artment of Ho	ealth and I <b>be</b> ath		iene 9g. NQ	1. 20007
	Physicia /Medic	an	1. Decedent's Name (First, Middle, I	SMITH				2. Date of Deat Month	h Day Ye	9ar 8: 26 AM
	Examin		4a. Facility Name (If not institution, g	. 1 / /	SP.	4b. City, Town, or	180	1	4c. County of I	Deeth
	Funeral Director		5. Social Security Number 215-76-3439  Usuel Residence of Decedent	Sex 7. Age (In	Yrs. last birthday Yrs.	If Under 1 Year     Months   Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Maryland -f show		10a. State 10b. County	100	c. City, Town or L					10d. Inside City Limits 1 177Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 4/03 Bi Ei	RMAN A		10f. Zip Code 2/2	06	1	Og. Citizen of Wha	it Country?
5-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show ha Madical Examinar must be notillied at	by Fur	11. Marital Status  1 Never Married 2 Married 5 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?		. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc,  BIACK
21215-0	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "netural", or Items 23a or 28a-f show item 27 is marked other than "netural", or Items and Item of Items of the traumatic event. In Medical Examinar must be notilized at	Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired)	luring most of wo	rking	16b. Kind of Busin	ess/Industry
yland	iould be filed Mental Hygi barked other batic event.	To Be C	17. Father's Name (First, Middle, La	smith			18. Mother's Nat	ne (First, Middle, M	Maiden Sylmame)	bMAN
ore, Mary	es 1 and 2 sho of Health and fitem 27 is m r other traum	. e	19a. Informant's Name/Relationship  MRRUNE  20a. Method of Disposition  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TUBMAN	Ob. Place of Disp	ling Address (Street a 103 Ei E position (Name of ematory or other place	BMAI	Ne.	BOLTO	ate, Zip Code)  O MA 21206  y or Town, State
altimor	permit. Page Department o Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie	city)	M +.	CARMO 22. Name and Addres CRAM		14-84 -Chow	DONO <- Wes	APLE MO
	20259		23a. Part1. Enter the disease, or to shock, or heert failure. List or	Implications that caused the lay one cause in gach line.		2 4 21	12 1 57	ally	950-1	Approximate Interval Between
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Due to (or as a co	ensequence of:	rderm	werl	nd od	a	Charland Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to i. c. a co	onsequence A	ge ver		400		12001 2014ears
O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	]Fétal déath 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	,
٥.	wrequires that the death been signed by the atte should be detached for	b	Part II Other significant condition	s contributing to death but no	ot resulting in the	underlying cause give	on in Part I.	23e. Did tot	1	ite to the cause of death?  Probably 4 Unknown
of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	/					24a. Was a autops perform	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
of Vita	hysician: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1X Inpatient	2 ER/Outpatie	- Indiana	er: 4 🗌 Nursing F	ath (Check only on	ince 6 Other (	(Specify)
Division o	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death   Thatural   5   Pending investiga   2   Accident   3   Suicide   4   Homicide	t be	At home, farm, s	Work M 1 □ Y	at i? ∕es 2 □ No		reet and Number of	or Rural Route Number,
Ō	ospital or hours afte ineral Dir		29a. Certifier 1 Certifying	Physician: To the best of m	ıy knowledge, dea	ath occurred at the tim	ne, date and place	, and due to the ca	ause(s) and manne	er as stated.
_	To the Ho within 24   To the Fu	Medical	(Check only 2 Medical Exone)  29b. Signature and title of certifie	caminer: On the basis of exa and manner stated	amination and/or in	29c. License	number	2	9d. Date signed 1	Month, Day, Year)
			30 Name and address of person w	no completed cause of death	(Item 23a) (Type	NE 0-1	75 22	SALT.	8/12/2	2004
	Sta	ate	TAUL LIGHT  31. Date filed (Month, Day, Year)	1541143 2 32. Registrar's	ZZ S.C Signature	REEN!	St.	SALI.	MO Z	YZel
	Regist	-	SEP 0 7 2004	Serent 1	& Sou	all		/		

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		g. No.?	20000
			Decedent's Neme (First, Middle, Last)	2. Date of Death		3: Time of Death
	Physic		BETTE STICKMAN	Month SEPT	Dey Year 5 2004	12:48 PM
	/Medi Examir		4a Fecility Neme (If not institution, give street end number)  4b. City, Town, or Lo		4c. County of Deet	
1			Westminster Nursing Center Westmin	ster	CARRO	14
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		9. Birti	nplace (State or Foreign
	Director		216 38 4651 1 M 20 F 63 Yrs. Months Deys Hours Min.	FEB 16	1941 7	MARYLAND
	p >		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			
	aryle sho	-				10d. Inside City Limits 1 XYes 2 □ No
	ha M	ecto				
	with w	Ö	10e. Street end Number 10f. Zip Code 21158	10	g. Citizen of What Co	4
	72 hours after death with the Marylend natural', or items 23a or 28a-f show disal Examiner must be notified at	Funeral Director		neitri Van au Ma	U - S - F	•
_	iter d	Š	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married  12. Was Decedent of Hispanic Origin? (Specific Armed Forces)  13. Was Decedent of Hispanic Origin? (Specific Armed Forces)  14. Was Decedent of Hispanic Origin? (Specific Armed Forces)  15. Was Decedent of Hispanic Origin? (Specific Armed Forces)  16. Was Decedent of Hispanic Origin? (Specific Armed Forces)	Rican, etc.)	Black, White	
220	irs af	by	If Yes, Give 1 ☐ Yes 2 ♣ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: []	hite
21215-0020	2 hou	be	15. Decedent's Education 16a. Decedent's Usual Occupation	10	6b. Kind of Business/I	ndustry
215	E - 2	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	ing		
2		NO.	12 O Key Punch Oferato,	R C	speen spr	ing WAIRY
pu	m - 0 =	Be (	17. Fether's Neme (First, Middle, Last)  18. Mother's Name	. A 1	- 4	
Va	Manta Manta Irked Itic ev	10	MILTON STIEKMAN Ethe	1 Ash	DAUGH	
Maryland	2 sho end is me		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure	I Route Number,	City or Town, State, Z	
_	and ealth n 27		BARBARCE Tyler/ Friend 2109 Liberty Lake De		ykesville i	
ore	Pages 1		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	.1.1	Oc. Location - City or T	
Ē	mant mant ant:		4 Donation 5 Other (Specify) LAKEVIEW Mem. PAICK 7		sykesville,	
Baltimore	permit. P Departm Importer any Injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		W	
	70 = 9 Q		Thought Jumpium 6028 Sytesville R	and Ele	rensburg, m	10 21784
			23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory arres	t,	Approximate Interval Between
	Physician				1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Metastaba Cancer of	Colo	m	
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	death certificate be executad e ettending physician and od for use as the bunal-transit	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		3 6	
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68	ificat g phy as th	8	resulting in death) Last			
Вох		M	a Chamic dianting	-		
œ.	death e ette	Sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use contribute i	to the cause of death?
P.O.	e law requiras that the death oe has been signed by the ettendi ge 2 should be detached for use	Physician/	Chronic Renal Failure			bably 4 Uniterfown
	gned be de	Ď	- Counce Terray I culture			
ord	en si ould	Completed		24a. Was an	autopsy 24b. W	Vere autopsy findings vailable prior to
e C	as be	Die.	MIN.		co	ompletion of cause death?
<u>~</u>	The ate h	ĕ		1 TYES	2 1	□Yes 2□ No
)įta	Physiclan: rthis certific ral director,	Be	25. Was case referred to medical examiner?	(Check only one)		
5	hysic his o	은		ne 5□Resideno	ce 6 □Other (Speci	fy)
ت د	Ing P	ü	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Sic	Attending or death.	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	201 1		
Division of Vital Records,	or Al	Certification:	4 ☐ Homicide  determined  determined  28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify)	City or Town,	et and Number or Rur Stete)	al Houte Number,
	purs sours eral	2	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place a	and due to the anu	20(2) and manner as	
	To the Hospital or Attending Physician: The is within 24 but on the within 24 but of the thousa the dath.  To this Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  1	ed at the time, date	and place, and due t	o the cause(s)
	To the Vithin To the	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month,	Day, Year)
	/		KKIGU Ceneur MD D-0054;	218 6	9-06	-04
	5	1	30. Name and an ress of person who completed cause of death (Item 23e) (Type, Print)	,5	, ,	
			30. Name and across of person who completed cause of death (Item 23e) (Type, Print)  DR. RAMAN B Kanena 349 Malailm Drive,	Went	nunita MI	) 2115n
No.	Sta	te	31. Dete filed (Month, Day, Year) 32. Registrer's Signature			,
	Registr	ar	orna mood (L) to day			

ORIGINAL

DHMH 16 Rev 6/95

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			1 _ State	State of Maryland / I	Department of Health and	Mental Hygier	
_			1 - State Registrar		Certificate of Death	Reg. I	
	Physici	an	1. Decedent's Name (First, Middle, La	Yalhar	Slace	2. Date of Death Month	Day Year 19:10 M
	/Media	al	10seph F	tr thur	Snarman sr		0 4001
4	Examir	er	4a. Facility Name (If not institution, give The Johns Hz	11 1	4b. City, Town, or Location of Deat	To the	Satimore City
	Current		5. Social Security Number 6. S	PKINS 105PIT		8. Date of Birth	
	Funeral Director			FT M OF F	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10/1/1942	Country) MD
	P		Usual Residence of Decedent				
	arylar show	Ę.	10a. State 10b. County Anne Aru	10c. City, Tow	n or Location Severn		10d. Inside City Limits
	8a-f	ectc	FID	muer			1 ☐ Yes 2 X No
	ours after death with the Maryland 'al', or itama 23a or 28a-f show Examinat must be notilied at	Funeral Director	10e. Street and Number 832 Lucky Road		10f. Zip Code 21144	10g. (	Citizen of What Country?
	eath na 23	era	11. Marital Status	12. Was Decedent Ever in U.S.		Specify Yes or No-	14. Race - American Indian,
(0	r itan	Fun	1 Never Married 2 Married	Ammed Forces? 1 A Yes 2 □ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
5-0036	hours after tural', or ita al Examina	by	3 Widowed 4 Divorced	If Yes, Give Navy Year or Dates: Navy	1 ☐ Yes 2 ☑ No Specify:		Specify: white
5-0	72 na	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16a.	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
121	- 30	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT use retired) Truck Driver		UPS
2	ba filed withir ital Hygiene. Id other than event, tre Meneral	ပိ	12 17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	
au	0 0 0	o Be	Alan Preston	Sharman		a Ann Siebe	· ·
Maryland 2121	2 should ba and Mental la marked aumatic ev	유	19a. Informant's Name/Relationship (7	Type, Print) 19b	o. Mailing Address (Street and Number or Ri	ural Route Number. City	or Town, State, Zip Code)
	s 1 and 2 should f Health and Men item 27 la marke other traumatic		Mrs. Beverly A. Sh		32 Lucky Road, Sever		
re,			20a. Method of Disposition	20b. Place of	f Disposition (Name of ry, crematory or other place)	Date 20c.	Location - City or Town, State
E	it. Page artment o ortant: If injury or		1 ☐ Burial 2 🖾 Cremation 3 🗆  4 🗇 Donation 5 🖾 Other (Specify	Removal from State Chesap	peake Cremation 9/4/	2004 Ste	vensville, MD
Baltimore,	pernit. Page Depirtment o Important: If any injury or once.		21. Signature of Funeral Service Licen		22. Name and Address of Facility S	ingleton Fu	neral Home P.A.
_	207 29 20		Dona Wallas	M01364	1 Second Ave SW G1		D 21061
Р				olications that caused the death. Do none cause on each line.	not enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a_ Sepsis			Iday
	/Medical Examiner			Due to (or as a consequence		4.02	Edour
-		er	Sequentially list conditions,	b. Pub to (or as a nonsequence	n organ failu	re	30/4/2
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	ate be executed hysician and he burial-transit	Exa	resulting in death) Last	Due to (or as a consequence	of):		
3760,	res that the death certificate be exigned by the attending physician be detached for use as the buria	ical		d			
x 68	certifica Iding ph Ise as th	Physician/Med	IF FEMALE:				
Вох	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delivery  Month Day Year
P.O.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		,
	requires that the een signed by thi lould be detacha	-Ph	Part II. Other significant conditions of	ontributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds	uires n sign lid be	d by				1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	> 9 %	Completed				24a. Was an	24b. Were autopsy findings available
Re	0 5 0	E O				autopsy performed?	prior to completion of cause of death?
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical		26 Place of Dea	1  Yes 2  N ath (Check only one)	o 1 ☐ Yes 2 No
>	S 0 D	To B	examiner? 1 \subseteq Yes 2 \times No	Hospital: 1 Inpatient 2 ER/Ou	Othor	Iome 5 Residence	6 □Other (Specify)
n of	ding Ph. h. After thi funeral		27. Manner of Death 1 A Natural 5 □ Pending		Time of 28c. Injury at Work?	28d. Describe how inj	
Siol	Attending r death. actor: After by the funer	catic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	pital ours a eral C	Ce	29a. Certifier 17 Certifying Ph	valeing. To the best of muliconded			
\	the Hospital hin 24 hours a the Funeral in	Medicai	(Check only 2 Medicel Exem	iner: On the basis of examination and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
1)	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
	->-0		> Worlen	N.O	RES-000	.   0	9-02-2004
3			30. Name and address of person who o	completed cause of death (Item 23a)	(Type, Print)	1011	1-1-11
	<u> </u>		JAY K. PSHAN	A, MD	600 N. WOlfe Stre	e+,/59/+1N	101e, MD 21287
	Sta Registr		31. Date filed (Month, Day, Year) SFP 0 7 2004	32. Registrar's Signature	Sm. 61		

		1 - State Registrar	t and			rtificate				2. Date of De	Reg. No.		( O U ) U
Physic	ian	Decedent's Name (First, Middle,	, <i>Last)</i> Franc	es G.	S	mith				Month	Day	Year	3. Time of Beath
/Med		4a. Facility Name (If not institution,					Town, or	Location o	of Death	Septe	mber 1	nty of Death	9:00 P ^M
Exami	ner	2825 Lodge Far		pt. 330			_	emere					ore Co.
Funeral			6. Sex 7	7. Age (In yrs. Ia	st birthday)	If Under Months	-	If Under	,	8. Date of Bir (Month, Da			lace (State or Foreign
Director		216-12-6144	1 M 2KOF	80	Yrs.	WOTHIS	Days	Tiodio		March	22,19	24 Mai	yland
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits
Mary -f she	tor	Maryland B	Baltimore						Eđ	gemere			1 ☐ Yes 2★☐ No
h the	irec	10e. Street and Number	<u></u>	<del> </del>		10f. Zip	Code			90020	10g. Citizen	of What Cour	itry?
23a c	al D	2825 Lodge Far	m Road A	pt. 330				2121	_			ed Stat	es
5-UU36 72 hours after death with the Maryland natural", or Items 23a or 28a-f show afted Enarch st must be invitited at	Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U.S ces?	13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	)- 14. I	Race - Americ Black, White,	
rs afte	by F	1 ☐ Never Married 2 ☐ Marrie  3 ② Widowed 4 ☐ Divorced	ed 1 Tes 1 If Yes, Give Year or Da	3		1 ☐ Yes	2 <b>X</b> No	Specify:			Spe	cify:	Mhite
2 hou	ed	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind o	f Business/Inc	
Z1Z15-UU36 ed within 72 hours aff giene. er than "natural", or the Nedicul Eneral	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed)  College (1-	4or 5+)	(Give life.	kind of wor DO NOT us	ork done d se retired	during mosi t)	t of workii	ng			
d 212 filed withii Hygiene. other than	Con	12 Years			H	airdr	esse	4-				notolog	J.Y
Maryland of 2 should be file th and Mental Hy 27 Is marked oth traumatic event	Be	17. Father's Name (First, Middle, L Frank Jancuk	Last)					18. Mothe		<i>(First, Middle</i> briela			
faryland 2 should be f and Mental H is marked of	2	19a. Informant's Name/Relationsh	sin (Type Print)		10b Maili	na Addrocc	(Straat	and Numbe		I Route Numb			
ire, Maryland Z1Z15-UUSD s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Iten 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event, the Medical Event in er must be notified at		Patricia M. Mo		hter									nd 21220
Baltimore, IN permit. Pages 1 and 5 Department of Health important: If item 27 any njury or other tr once.		20a. Method of Disposition			ace of Dispo				D	ate	20c. Location	on - City or To	wn, State
<b>SAITIMORE,</b> Dermit. Pages 1 a Department of Hez mportant: If item sny njury or othe page.		1 🛣 Burial 2 □ Cremation  1 🛣 Donation 5 □ Other (Sp		iate	metery, cre $1 \mathrm{y}$ $\mathrm{Hi}$	_			9/4/	2004	Midd	le Riv	ver, MD
Dalti permit. Departm Importa any nju		21. Signal re of June al Service L		0/1	2	2. Name an	nd Addres	ss of Facilit	¥a1	Home of			
<b>n</b> &&££5		Mall 11	1/12	00/11						ndalk,		•	222
	1	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca only one cause on ea	used the death. ich line.									Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a. Isch	remir	A.								
/Medical Examiner		resulting in death)			1100	1-True	DIS	seas	se				Onset and Death
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uted 1 ansit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseque	ence of):					, (IO) V USSA	wher t	Diseus	Zyrs
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ath certificate be executed ath certificate be executed thending physician and or use as the burial-transit	Examiner	resulting in death) Last  ### FEMALE:  23b. Was decedent pregnant	Due to (o  Due to (o  C	or as a consequence or as a consequence of pregnanth 2 ☐ Fetal c	ence of):  Provide the control of th	Les Salaria de la Companya de la Com	regnancy			ÚDV u saí	23d.	Date of delive	zyrs
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Certification; To Be Completed by Physician/Medical Examiner	### Initiated events resulting in death) Last  #### IFFEMALE:  ### 23b. Was decedent pregnant in the past 12 months?  ### 1	Due to (or	or as a consequence or as a consequence of pregnan and 2 Fetal control at time of dealers of the control at time of dealers or as a consequence or as a consequence of Fetal control at time of dealers or as a consequence of Fetal control at time of dealers or as a consequence of Fetal control at time of dealers or as a consequence of Fetal control at time of the control at time of time of	ence of):  Provide at the unit of the unit	Ectopic production of the course of the cour	regnancy pecify)  Pause give work of the time, in my open cells. Licensee	26. Place en: 4 \( \text{Nu}\) \text{vat} \text{ves} 2 \( \text{l} \) \text{ne, date anoinion, deal} \text{en number}	of Death rising Hon A No A d place, a	23e. Did to the dat the time,	obacco use control of the state	Date of delive Month  ontribute to the  3 Prob  b. Were auto prior to cordeath? 1 Yes  Other (Specify curred  manner as stee, and due to  med (Month, 1)	Poly Year  e cause of death?  ably 4 Unknown  by findings available inpletion of cause of 2 No  Poute Number,  ated. the cause(s)  Day, Year)

RKD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28, **Physician** AUGUST 2004 9:20P. M Michael T. Slaughter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ST.AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1.□M 2□ F Director Yrs. 05/04/1963 Maryland 220-80-2132 Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or itams 23a or 28a-f shov traumatic event, it a M. algal Exc. when reust be notified at 1 Yes 2 No Director Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3031 Harlem Ave 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles H. Slaughter Elizabeth A. Jeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is any injury or other trau 1304 Pennsylvania Ave Apt2
ce of Disposition (Name of Date Elizabeth Jeter Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Carmel Cemetery 09/08/2004 Baltimore, Maryland * 4 ☐Donation = 5 ☐ Other (Specify) 22. Name and Address of Facility Wise Funeral Services, P.A. 21. Signature of Funeral Service Licensee 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumotherax Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner complications of Chanic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 1 🗶 Yes 2 No 2[] No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending hours after death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) outhall. Mi O.C.M.E. AUGUST 29,2004 11 Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southall mi 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 12:58 PM S Turso 0 9 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Uni vensiti Baltimore  $C_1 + \gamma$ M.D | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APR 22, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 New York **Funeral** 1□M 2\ F 069-54-0465 31 Yrs. 1973 **Director** Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-i show 1 ☐ Yes 2 No Maryland Wicomico Salisbury Direc 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 217 Wall Street 21804 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give A
Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1□Yes 2HNo Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be and Mental marked o 27 is marked traumatic e Robert Turso Vicki Stratton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Danielle Santiago/Sister 3006 Highland House Villas Ct. Arnold, MO 63010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 9/7/04 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain **Physician** herni day /Medical Due to (or as a consequence of): Examiner aumat 24 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner 0 Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit 97 ٥ Due to (or as a consequence of): P.O. Box 68760, physician the MEDICAL use as I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ one 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate ha 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending Injury 1:35 Moter Vehicle 04 1 ☐ Yes 2 No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Stree Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tren MA7266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD and 2035 Red vd SEP 0 32. Registrar's Signature 31. Date filed (Month, State 7 2004 Registrar

			For State Registrar	State of Maryland		rtment of F			giene	16 2809	3
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	Funeral Director		5. Social Security Number 6. Sep 564-52-7360 Usual Residence of Decedent	7. Age (In yrs. Ias	et birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		n v. Year)	9. Birthplace (State or Fo	
	ne Maryland 8e-f ehow alified at	ctor	10a. State 10b. County  California Orang		Town or Loc	Anahe	im			10d. Inside City L 1 ☐ Yes 2 〔	
	with the Sa or 2	Dire	10e. Street and Number 208 W. Sirius Av	remile		10f. Zip Code	802		10g. Citizen of 1	What Country? USA	
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altimore,	nit. Pages 1 an artment of Heal ortent: If item 2 injury or other		20a. Method of Disposition 1 ☐ Burial 24 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	20b. Plac	e of Disposi netery, crema	tion (Name of atory or other place ematory,	ce)	Date	20c. Location -	City or Town, State	
Balt	perrit. Pages Department of Importent: if it any njury or o		21. Signature of F. ner Service Licens  Dawn F. M	MC Mule cDonald	-129	9 Freder	rick Roa	of Mary d Baltin	nore. M	D 21228	٠
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	10		30. Name and address of person who co			rint)		u. la	J 212	3/2004	
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8 8 1		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ing Address (Street	and Number or F	Ru <i>ral R</i> oute Numi	ber, City or To	wn, State, Zi	ip Code)	
If item 27 is marke or other traumatic	_	Talisa Weston-	Daughter		Chelse	a Terra					
or of the	2	20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location	on - City or T	own, State	
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State of Maryland / Department of Health and Mental Hygiene

							Cei	tificate	of Death		Reg. No	O.L.	22005
			1. Decedent's Name	(First, Middle, L.						2. Dete of Month	Deeth Dey	Year	3. Time of Death
***	Physicia /Medica		Jeannette C. Turlington								mber 1	2004	1 6:55PM
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	Funeral Director	5. Sociel Security Number 214-38-6232 6. Sex 1 Months 1 M 2 TF 64 Yrs. 1 Months Days Hours Min								Min. (Month,	Birth Dey, Yeer) Ser 5,191		place (Stete or Foreign ntry) cyland
	P .	-	Usuel Residence of 10a. Stete	Decedent 10b. County		10c Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
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	ter death with the Marylar terms 23a or 28a-1 show	Funeral Director	10e. Street end Num		1			10f. Zip C	ode 21090		10g. Citizen of		
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		+	23a. Part Enter th	e diseese, or cor	mplications that caus	ed the deat	th. Do not ent	er the mode	of dying, such as	cardiac or respirator	y errest,	1	Approximate Interval Between
	Physician /Medical Examiner		Immediete Cause (F disease or condition resulting in death)	inal	е	De	tost or es a consec		Soc	+ tossno	Sarco	ma	Onset and Death
	ficate be executed physician end is the buriel-transit	Examiner	Sequentially list con if eny, leading to impause. Enter Under Ceuse (Disease or in	ditions,	b	Due to (	or es a conseq	uence of):			\	- 1	
x 68760,	ntificate be ng physicla s es the bur	Medicai	Ceuse (Disease or injury that initiated events resulting in death) Last  Due to (or as e consequence of):										
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<u>≻</u>		2	1 ☐ Yes 2 ☑ N		Hospital: 1 🗆 Inpa		ER/Outpatier			rsing Home 5			v)
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Division of Vital Record	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigetion 6 Could not independent	be 28e. Place of I	njury - At h etc. <i>(Specia</i>	ome, farm, str fy)			28f. Location	n (Street and Nurr Town, State)	nber or Rure	I Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Sr. Gilbert Thiess, 8 31 2004 8:35 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 110 Oak Avenue Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 2, 1936 5. Social Security Number 6. Sex Birthplace (State or Foreign MD Country) 7. Age (In vrs. last birthday) **Funeral** 1 √ M 2 ☐ F 216-32-9098 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or Itams 23a or 28e-f ebov other traumatic event, the Medical Exertiner must be rotified at 1 Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Oak Avenue 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Marned 1□ Yes 2☐ No Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within; the and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self Employed 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Christian Thiess, Sr. Erma Virginia Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. 110 Oak Avenue, Glen Burnie, MD 21061 Mrs. Darlene Thiess / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park Sep. 4,2004 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 10/357 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit THEROSCLEROSIS and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physicien hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No detached 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, GRIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown been RINARY TRACT INFECTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 ⊠ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D the Hospitel 图 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) markenskummy D57574 9/1/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLENBURME MO 21061 CRAIN 6A 1412 NORTH HWY 82. Registrar's Signatur 31. Date filed (Month, Day, Year) State SEP 07 2004 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical Examiner

**Funeral** Director

or 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Insportant: If item 27 is marked other than "netural", or items 23a or 28a-1 ahov amy injury or other traumatic evant, it a Medical Evant are must be notified at once.

WATSCN, MORLEY

Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** 

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: A filled in by

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er	4a. Facility Name (/	f not institution, give	street and number	r)		4b. C	ity, Tow	n, or Location	of Death	,	4c. C	County of Death	1	
	FRANKLIN	SOUARE	HOSPITAL	CEN	TER	RO	SE	DALE			B	ALTIMO	DRE	
	5. Social Security N 214 46 1	umber 6. Se	x 7. A	ige (In yrs. 58	last birthda Yrs.	Mont	der 1 Ye hs Da		Min.	8. Date of Bir (Month, Da NOV 25	y, Year)	Cot	npiace (Stete or For Intry) UTVland	reigi
	Usual Residence of	Decedent									•			_
or.	10a. State	10b. County		1 □Yes								10d. Inside City Lin 1 ☐ Yes 2 反		
ctc	MD	Baltimor	:e		Middl						10= Citiz	en of What Co	inter?	
al Dire	10e. Street and Nur. 9807 AV:					107.	Zip Cod 212					ted Sta		
Completed by Funeral Director	11. Marital Status  1 Never Marr 3 Widowed	ied 2□ Married 4 ☑ Divorced	12. Was Deceder Armed Forces 1 \( \text{Yes} \) 2 \( \text{If Yes, Give} \) Year or Dates	;? <b>∑</b> No	.S. 1	3. Was De If Yes, s	specify (	Cuban, Mexic	an, Puerto F	cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify:		
leted		15. Decedent's Edu	le completed)		(G	cedent's l ive kind of e. DO NO	work do	one during mo	ost of workin	g	16b. Kin	d of Business/I	ndustry	
Ę	Elementary/Seco	ondary (0-12)	College (1-4o	r 5+)		usto					Sch	∞ls		
S	17. Father's Name	(First, Middle, Last)				asux	ALCII I		her's Name	(First, Middle				
To Be	Morley W	atson						Mae	G. W.	indsor				
. 1	19a. Informant's N	ame/Relationship (T)	ype, Print)		19b. Ma	ailing Addr	ress (St.	reet and Num	ber or Rura	Route Numb	er, Cîty or	Town, State, Z	îp Code)	
	Micah L. Watson/Son 2413 59th Place Cheverly, MD 20785  202 Mathod of Disposition (Name of Date 202, Location - City or Tow													
		position  Cremation 3   F			cemetery, o	rematory	or other			ate 2004		idge, M		
		uneral Service Lipens					-			rv H. V	Witzk	e's Fan	ily FH I	nc
1	Men	Collu	à Will	To a	1								MD 2104	
e e	23a. Part1. Enter shock, or hea	the disease, or comp art failure. List only o			th. Do not	enter the r	mode of	dying, such a	as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Deat	n
	disease or condition resulting in death)		a. MYOC Due to (or a			11	)FA	RCTI	ON				6 Days	
ner	Sequentially list co if any, leading to in Cause (Disease of		b. Due to (or a	as a consec	quence of):									
mi	that initiated event	S 📰	c		quence of):							-		
al Ex	resulting in death)	Last	Due to (or a	as a consec										
olbe			u											
ysician/Medical Examiner	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?	nancy tal death 3						2	3d. Date of deli Month	ivery Day Year			
Ph	Part II. Other signi	ificant conditions co	ontributing to death	but not res	sulting in th	e underlyi	ng caus	e given in Par	rt I.	23e. Did	tobacco us	se contribute to	the cause of death	1?
ed by										1 🗆	Yes 2□	No 3□Pr	obably 4 Unkn	lowi
Completed by Phy										24a. Was auto perf 1 ☐ Yes		prior to death?	topsy findings avail completion of cause	labi e of
a)	25. Was case refe	rred to medical						26. Pla	ice of Death	(Check only				_
OB	examiner?		Hospital: 1 Hnpa	atient 2	ER/Outpa	itient 3	DOA	Other		_		Other (Spec	cify)	
-	27. Manner of Dea	ith 5 ☐ Pending	28a. Date of la (Month, la		28b. Tim Inju	e of		Injury at Work? 1 \sum Yes 2	2	28d. Describe				
Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6  Could not be determined	28e. Place of	Injury - At h etc. (Speci			ctory, of				(Street and own, State)	l Number or Ru	ural Route Number,	
ŭ									1.					

State Registrar DHMH 17 Rev 1/2001

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

ANASTASIOS P. 31. Date filed (Month, Day, Year)

SEP 0 7 2004

29a. Certifier (Check only one)

29b. Signature

SALIARIS, MERANKLIN SQUARE HOSPITAL CENTER

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital

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State Registrar

31. Date filed (Month, Day, Year) **SEP 0.7** 2004

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BRADAUSKAITE 1912 y, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year) SEPTEMBER 3, 2004

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State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 11:00 AM 2004 Doris Ann Winchell Sept. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8 Alder Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 58 MAR 8. 1946 Michigan Director 367**-**46-4207 Usual Residence of Decedent 1 and 2 should be filled within 72 hours after death with the Maryland Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23c or 28a-f show 1 ☐ Yes 2X No Directo Maryland Annapolis Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA 8 Alder Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than . Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Publisher is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Roger Winchell Betty Jane Hanes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Item 27 is Annapolis, MD 21403 David G. Ewing/Husband Alder Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ☐ Burial 2 XCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Metro Crematory, Inc. Baltimore, MD 22 Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Censee
Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician etusto /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? è 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Vene 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: funeral director, 26. Place of Death (Check only one, 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 3 DOA Medical Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi son who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Dav. Year) 32. Regis State

DHMH 17 Rev 1/2001

Registrar

2004

				State of Maryla	nd / Dep	artment of H	ealth and M	•	•	oie.	
			1 - State Registrar		Ce	rtificate of L	Death	R	eg. Nø.	14 28101	
ı	Physici /Medic		1. Decedent's Name (First, Middle, La	bd				2. Date of Dea Month AUGUS	↓ Day	Year 2004 1117 AM	
	Examin		4a. Facility Name (If not institution, gi	nary land Med	ical center	4b. City, Town, or	Location of Death		4c. County	of Deeth	
	Funeral Director		N/A	Sex 7. Age (In yrs	yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 8/25/		Birthplace (State or Foreig Country)     MARYLAND	
3	A		Usual Residence of Decedent  10a. State 10b. County	10c. C	city, Town or Le	ocation				10d. Inside City Limi	
	28a-f eh	ector	MD ANNE A	RUNDEL :	SEVERN	10f. Zip Code	<u>.</u>	Τ,	0g. Citizen of W	1 Tyes 2 X	
	Baor	2	1450 WATTS AVENU	ΙE		2114	4			mat Country :	
2	uges I and a should be first which it is not a state occur with the way and to the Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23s or 28s-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	1X Never Married 2 Married 1 Yes 2 No			Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	Black	- American Indian, k, White, etc.		
Ś.	turel',	ed b	3 Widowed 4 Divorced  15. Decedent's 8	Year or Dates:	16a Dece	dent's Usual Occupa	tion		16b. Kind of Bu		
0000-01717	n ne	Completed	(Specify only highest gi	College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	done during most of working			sinessinoustry	
7	giene giene ar the	mo.	N/A N/A		N/A	N/A			N/A		
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Maiy	and 2 should balth and Meni n 27 Is marke ler treumatic	<b>,</b>	19a. Informant's Name/Relationship CHARNAE WOOD	(Type, Print) MOTHER		ng Address (Street a			; City or Town, S 21144	State, Zip Code)	
U,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tro once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	Place of Dispo cemetery, cre NG MEMO	osition (Name of matory or other place ORTAL.				City or Town, State MILLS, MD	
	Department Importent:   any injury c		21. Signature of Funeral Service Lice			2. Name and Address				AL HOME, P.A.	
Ď	Deparation of the series of th		) /	SON, MD							
E	hysician and sician and purial-transit and purial-t	cal Examiner	disease or condition resulting in death)  Sacuantully list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consec	equence of):  Over the property of the propert	inary o ric sho premi	arvest CK atuni	ty			
P.O. BOX 00	The raw requires that the death certificate by executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[	Ectopic pregnancy Other (specify)			23d. Date Mon	o of delivery th Day Year	
C3, L	been signed by the should be detached	d by Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying cause give	n in Part I.	23e. Did tol	/	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknow	
necolus,	ate has beer page 2 shou	Completed						24a. Was a autops perform	y pr ned? de	fere autopsy findings available for to completion of cause of eath?	
סו אוומו	certificate	Be (	25. Was case referred to medical examiner?					th (Check only on	e)		
5	rthis certific	은	1 ☐ Yes 2 X No		ER/Outpatie		4 Little Sing Th	ome 5 Reside			
DIVISION	fte ing	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide  5 Pending investigation 6 Could not	ne -	28b. Time o	Work M 1□Y	at ? ′es 2 □ No	28d. Describe ho			
2	ital of At its after of rel Direct led in by	Certifi	4 Homicide determine	building, etc. (Spec	cify)			City or Town	n, State)	r or Rural Route Number,	
	vithin 24 hours after death.  To the Funeral Director; A completely filled in by the fu	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exe	hysicien: To the best of my ki miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	vestigation, in my op	inion, death occur	rred at the time, d	ate and place, a	nd due to the cause(s)	
ı	To the comp	M	29b. Signature and title of certifier	Falce,	MD	29c. License	number		9d. Date signed	(Month, Day, Year) + 26, 2001	
	/		30. Name and address of person who ALISON FALCK, MI				<b>ITAL</b> B	ALTIMORE	, MD 2	1201	
	Sta Registr		31. Date filed (Month, Day, Year) SFP 0 7 201	39. Registrar's Sign	nature	all a					

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Year

Division of Vital Records, Hospital or Attanding Physician:

> Registrar DHMH 17 Rev 1/2001

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Certification:

Medical

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death.

within 24 hours after death To tha Funaral Director:

To the

1X Yes 2 □ No

5 Pending

investigation

11.

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

6 Could not be determined

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

4 \ Homicide

(Check only one)

29b. Signature and title of certifier

THEO WAEM Ku
31. Date filed (Month, Day, Year)

SEP 0 7 2004

Accident

Registrar's Signature

1 Inpatient XXER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital:

28a. Date of Injury (Month, Day Year)

and manner stated.

**ORIGINAL** 

Other:

1 TYes

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) AUG. 31, 2004

		•	For State Registrar	State of Mary		artment of F			giene	20102	
			Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath	3. Time of Death	
	Physicia		SANIE		WILLIA	Ms		Month	Day Year	4 3-15AM	
	/Medic Examin	_	4a. Facility Name (If not institution,				r Location of Death		4c. County of Dea		
		٠	Bon Secours H			Baltim			N/A		
	Funeral			1 M 2 FVF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h 9. Bi	rthplace (State or Foreign country)	
	Director		219-20-8883 Usual Residence of Decedent	82	110.			April 2	0, 1922 No	rth Carolina	
	yland Now		10a. State 10b. County	100	c. City, Town or Lo	ocation			10d. Inside City Limit		
	e-f st	ctor	Maryland N/A	Ba	altimore					1 ves 2 □ No	
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?	
	ath w	La I	114 Williard			21223			USA		
	er de Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
36	irs aft	by F	3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black	
9	72 hours after death with the Maryland natural; or Items 23a or 28e-f show sigal Examinat the trollitied at	Completed by	15. Decedent'	s Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines:	s/Industry	
215	within 7 ene. than "r	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	ing			
21	e filed within al Hygiene. cother then ' vent, the Me		11		Cle	rk	40 14-15-1-1			urity Admin.	
Maryland 21215-0036	uld be fi fental H rked otl tic sver	Be	17. Father's Name (First, Middle, L	Corbett					Maiden Surname)	ith	
Z Z	2 should be and Mental Is marked eumatic sv	우	Liston  19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street	Anni		r, City or Town, State,		
Ma	nd 2 s lith an 27 is r treu		Ruby J. Young						re, MD. 21		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Importent: If item 27 Is marked other than "natural", or litems 23a or 28e-f show my injury or other treumatic event, It a Healtsal Examinat missible indifficity one.		20a. Method of Disposition	26	0b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City o	r Town, State	
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alti	permit. Departm Importe any inju		21. Signature of Furral Sirvice L	1					k Funeral		
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			23a Port1. Enter the disease, or othock, or heart failure. List of	complications that caused the only one cause on each line.	death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):				AT		
ы		ь	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):						
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	X	d							
9	leath certificate b attending physic I for use as the b	Med	IF FEMALE:	00-11							
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3[	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year	
o.	that the de ed by the detached	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	or death 3L						
0	that the ned by detac	by Pr	Part II. Other significant condition	ns contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
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Vital Records,	aw requas been 2 shoul	ompleted	, ,,,					24a. Was a		utopsy findings available completion of cause of	
Ä	The ate h	Сош						perfor			
/Ita	sicien: Th certificate irector, pag	Be (	25. Was case referred to medical examiner?	113-1		011	26. Place of Deat	h (Check only o	ne)		
of	Phys this al dii	To.	1 Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 R/Outpaties 28b. Time o		4   Nursing no		lence 6 Other (Spo	ecify)	
		tlon	1 Natural 5 ☐ Pending	(Month, Day Yea	ar) Injury	Wor	yat rk? Yes 2 □ No	ZOG. DOSCIDO II	low injury occurred		
Division	or Attending after death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Injury					Street and Number or F	Rural Route Number,	
ē	al or A s after il Dire	Certification:	4  Homicide	building, etc. (S	ipecity)			City or Tow	m, State)		
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	ths H in 24 the F nplete	ledi	one)	and manner stated.							
	To To	Σ	29b. Signature and title of certifier	1 2		29c. Licens	o number	'	29d. Date signed (Mon	an, Day, rear)	
7			0/		(Itom 22-) (To:	Drint)	1120	2,	711/0	24	
	if		30. Name and address of person v	mo completed cause of death		ENA A	LIE D	11 -11	MARC A.	021222	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S		LIXM A	0 5	p\$ 3 (	- IVE (VI	1)6166	
	Registr		SEP 0	7 2004 Heren	u K	Secule)					

State of Maryland / Department of Health and Mental Hygierie | | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 12:30a Physician Helen Gertrude Griffith Warner September 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 5601 Elele Court Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2□F 216-44-2609 Director Nov 13 1908 DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural", or items 23a or 28a-f show the Medical Examinat must be notified at Md Carroll Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5601 Elele Court 21784 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be fited within 72 hours after 1 ☐ Yes 2 € No If Yes, Give Å Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne any injury or other treumatic event, the Medie once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) federal government secretary 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John William Griffith Emma Kate Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W. Warner Jr. (son) 5601 Elele Ct., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3√ Removal from State Arlington National 9-22-04 * 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Va. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER S **Physician** 3 40915 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No
9 □ Unknown for Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 3 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physicien: After this certific tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Présidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number DZZZZZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mez mD 31. Date filed (Month, State Registrar

	-	For State Registrar	State of	Maryland /	-	ificate				Reg. No.	0001	28105
Physicia		Decedent's Name (First, Middle,     Table 1.1.		leon					2. Date of Month Sep1	Death Day	2004 Year	3. Time of Death 5:30p M
/Medic	al -	LVan  4a. Facility Name (If not institution,	Junior Wi			4h City To	wn orlo	ocation of De			County of Death	1
Examin	er	Ruxton Heal		luer)		Pikes					Baltimor	
uneral rector		5. Social Security Number 210-18-1004	6. Sex 1 M 2 □ F	7. Age (In yrs. last 79	birthday)_ Yrs.	If Under 1 Months E		f Under 24 H Hours M	in. Apri.	Birth (Par)	9. Birth 1925 Wes	place (State or Foreig (Mry) Virginia
		Usual Residence of Decedent		10c. City, T	own or Loc	ation						10d. Inside City Limit:
show a la	ក	Md. Balti	more		kesvi							1 ☐ Yes 2 📉 N
28a-f	ect	10e. Street and Number	11016			10f. Zip Ci	ode			10g. Cit	izen of What Cou	intry?
585	ā	4 Sudbrook	Lane				212	802			U.S.A.	
T U	nera	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13. W	as Deceder Yes, specify	nt of Hispa	anic Origin? Mexican, Pu	(Specify Yes o erto Rican, etc.	r No-	14. Race - Ameri Black, White	
acolice	Completed by Funeral Director	1 Never Married 2 Married	ed 1 □XYys If Yes, Giv	2□No • WW TI		☐ Yes 2		Specify:			Specify: Whi	
al Ex	Q P	3 ☐ Widowed 4 € Divorced  15. Decedent	Year or Da		6a. Decede	ent's Usual (	Occupatio	20		16b. K	ind of Business/Ir	ndustry
Department of Health and Mental Hygiene. Important: If item 23s of 28s-f show important: If item 27 is marked other than "naturel", or Items 23s of 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at ances.	olete	(Specify only highes	t grade completed)		(Give k	ind of work O NOT use	done duri retired)	ing most of v	vorking		16b. Kind of Business/Industry	
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Vent,	Bec	17. Father's Name (First, Middle, L					18		lame <i>(First, Mic</i> rl Cath			
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raum		19a. Informant's Name/Relationsh									or Town, State, Zi Md. 212	
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yord		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.				remato		Se	pt. 7,2	004 Ba	ltimore	Md.
injui	H	21. Signature of Figural Service Licensee  22. Name and Address of Facility Eckhardt Funeral Chapel. P.A.										
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dical liner		resulting in death)	Due to (	or as a consequen	ice of):							
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9 23 2	by Physician/Med	IF FEMALE:		***								
Tor use as the	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregnancy firth 2  Fetal de ant at time of deat	ath 3 🗆	Ectopic preg					23d. Date of deline Month	very Day Year
t ped:	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno		u 2	Other (spec	Juy)					
detached for	/Ph	Part II. Other significant condition	ns contributing to de	eath but not resulting	ng in the un	derlying cau	ıse given	in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ed bluods	q p	Chronic obstru	KHUZ p.	11moras	y ;	1500	758		_ "	1 ☐ Yes 2	□No 3□Pro	bably 4 Unknow
suois 2	Completed	congestive V	negrt f	GILLIE						Was an autopsy	24b. Were aut	opsy findings available
rector, page 2 s	E									performed?	death?	2□ No
ctor, p	BeC	25. Was case referred to medical examiner?				-			Death (Check o			
9	ို	1 Yes 2 No				3□ DOA					6 □Other (Spec	ify)
0	no.	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	of Injury th, Day Year) 28	Bb. Time of Injury	M 28	c. Injury a Work?	ıt es 2 □ No	28d. Desc	ribe how inju	iry occurred	
P P		2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be Gen Blace	of Injury - At home	e. farm. stre			.5 2				ral Route Number,
ne funeral d	icati		buildi	ng, etc. (Specify)	, ,				City o	r Town, State	θ)	
ne funeral d	ertificati	4 Homicide determ			edge, death	occurred at	t the time,	, date and pl	ace, and due to	the cause(s	and manner as	stated.
n: Alter this ne funeral d	lical Certificati	4 Homicide determination deter	g Physician: To the Examiner: On the b	asis of examination	n and/or inv	estigation, i	n my opir	non, death o	Controd at the t	ime, date an	a place, and due	to the cause(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year **Physician** LESSIE MAE WALKER 0150 AN September Prop 9 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE AUGSBURG LUTHERN NURSING CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 93 214-24-3112 Yrs. Director 3-16-1911 NORTH CAROLINA Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours eftar death with the Meryland neat of Health end Mental Hyglane.
ant: If Itam 27 is marked other than "natural", or items 23a or 28a-f show unt: If Itam 27 is marked other than "natural", or items 23a or 28a-f show unt; If he Medical Examinal must be notified at uny or other traumatic event, the Medical Examinal must be notified at 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyres 2 □ No **Funeral Director** MD. N/A BALTIMORE 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 4010 BUCKINGHAM RD 21207 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-SEAMSTRESS TAILOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD W. HALL JANE L. MILLER 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21133 4115 HUNTERS HILL CIRCLE RANDALLSTOWN, MARYLAND KIMBERLY MILLER (FRIEND) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dapartment of Important: If It any injury or o 1 → Burial 2 Demation 3 Removal from State 4 Donation S ☐ Other (Specify) MARYLAND NATIONAL 9-8-2004 LAUREL, MARYLAND 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Par Examiner Due to (or as a consequence of): Physician/Medical Examiner attanding physician and for usa as the burial-transit Attanding Physician: The lew requires that the death cartificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Aftar this certificeta has bean signed by funaral diractor, paga 2 should ba dated 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? SNU 1 L Y 36 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠No Medical Certification: To 28c. Injury et Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation aftar daath. | Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier, 737 573 1000 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 54 21136 40, EVOTOU

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 7 2004

32. Registrar's Signature

			1 - State Amend Items Registrar	State of Maryland 7,20b,22 per Fl	d / Department of Hea H, G835, 99/07/04d	ılth and Mental Hy <b>İbb</b> <b>ath</b>	/giene Reg. N2 0 0 is 28 i i	7
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	Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Loc		4c. County of Death	.1.
				EALTH CARE	SALTIMO ast birthday) If Under 1 Year If			NA
L	Funeral Director		5. Social Security Number  212-80-6934  Usual Residence of Decedent	9X		Hours Min. 8. Date of Bi	(irth (ay, Year) 2 9. Birthplace (State or Country)	Fareign
	yland		10a. State 10b. County	10c. City	, Town or Location		10d. Inside Cit	y Limits
	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "naturel", or Iteme 23e or 28e-f show or other freumatic event, the Modical Evanting must be notified at	Director	10e. Street and Number	NA	Baltimo 10f. Zip Code	re	10g. Citizen of What Country?	2 🗆 No
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Ore	Pages 1 nent of H int: if ite		20a. Mathod of Disposition 1 Burial 2 Cremation 3	Removal from State	ace of Disposition (Name of imetery, crematory or other place)	9/3/2004	20c. Location - City or Town, State	
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	Examiner			Due to (or as a consequ	ence or).			
0	<b>-</b>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ence of):			
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	ence off:			
8760,	sate be executed obysician and the burial-transit	ajE			ance or,			
9	ificate g physas the	edical		. d				
О. Вох	The law requires that the death certificate be execuled ale has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Yo	ear
Δ.	signed by	y Ph	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the underlying cause given in	Part I. 23e. Did	tobacco use contribute to the cause of de	ath?
ords	w require been sig should b	ted t	HIV			10	Yes 2 No 3 Probably 4 Du	nknown
Records,	e law re has be je 2 sho	Completed by	UPPER GASTROI	NTESTINAL	BLEEDING	24a. Was	ppsy prior to completion of ca	vailable use of
E B	: The cate h	Con	HEPATIC ENCE	PHALOPATHY	1	perfe 1 Yes	ormed? death? 2 No 1 □ Yes 2 No	
of Vital	Physiclen: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	0.1	. Place of Death (Check only		
ō	Phys er this eral dii	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient 2 L	28b. Time of 28c. Injury at	4 Nursing Home 5 Res	idence 6 □Other (Specify) how injury occurred	
ion	Attending F death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Work? M 1 ☐ Yes	2 No		
Division	el or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office		(Street and Number or Rural Route Numb wn, State)	ier,
	To the Hospitel or Attending Physiclen: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death occurred at the time, don and/or investigation, in my opinio	late and place, and due to the in, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)	
	To th To th compl	Me	29b. Signature and title of certifier		29c License nu	1111	29d. Date signed (Month, Day, Year)	
	$\sim$		▶ Kagar Me	ena MD	H18	611	AUG. 26,200	4
	,0		30. Name and address of person who	completed cause of death (Item	INDUM =			
			31. Date filed (Month, Day, Year)	OF MEDICIN 32. Registr's Signer	E 900 CATO	N AVE BAL	TIMORE MD 212	29
	Sta		SEP 0 7 2004	Seem It 19				

YOUNG, FRANKLIN

1 - For State Registre

2. Date of Death 1. Decedent's Name (First, Middle, Last) 30,2004 Month **Physician** AUGUST 4:00A M ERNEST J. ZIMMERER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUPITAL BALTIMORE GOOD GAMARITAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/21/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🙀 M 2 🗆 F Yrs. Director 218-32-3406 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE PARKVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? itams 23a 2501 MICHELS LANE 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 6 1 ☐ Yes 2 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MEAT CUTTER 7TH GRADE SELF EMPLOYED or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental S. GEORGE ZIMMERER MARY ULLRICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once. ESTHER R. ZIMMERER WIFE 2501 MICHELS LANE BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 9/2/04 PARKVILLE, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death STROKE **Physician** /Medical Due to (or as a consequence of Examiner PNEUMONIA IRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and tor use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No To the Hos ital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Atter 1 Natural 5 Pending 1 Yes 2 No death investigation 2 Accident within 24 hours after deat To the Funeral Diractor: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier D00618 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCH RAVEN BLVD, BALTIMORE, MD 21239 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Registrar

			- FOI	Department of Health and MacCertificate of Death	Reg. NG, 004 28109
	Physicia /Medic		Decedent's Name (First, Middle, Last)     CONNIE L. ZI	NN	2. Date of Death 3. Time of Death 400th 09 - 03 - 2004 10:45P. M
	Examin		4a. Facility Name (If not institution, give street and number)  DULANEY TOWSON CARE CENTER	4b. City, Town, or Location of Death TOWSON	BALTIMORE
	Funeral Director		5. Social Security Number 408-46-5087 6. Sex 1 □ M ※ F 7. Age (In yrs. last birth 79	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) TENNESSEE
	ryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  MD. BALTIMORE	or Location TOWSON	10d. Inside City Limits 1 ☐ Yes ※  **No
	h the Ma or 28a-f s e notifie	Irecto	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death wi	Funeral Director	111 WEST ROAD  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	21204  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	U. S. A.  Decify Yes or No- D Rican, etc.)  14. Race - American Indian, Black, White, etc.
920	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show na Masileal Exertitive front is entitled at	þ	1 Never Married 2 Married 1 Yes, Give 3 Widowed XXDivorced Year or Dates:	1 ☐ Yes XX No Specify:	Specify: WHITE
21215-0036	hin 72 ho e. en natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry  OWN HOME
2	Hygi Hygi ther ont,	0	9 YEARS 17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
Maryland	thould be ind Mental inarked c matic eve	ToB	HOWARD LEE WILLIAMS  19a. Informant's Name/Relationship (Type, Print)  19b.	MARY  Mailing Address (Street and Number or Run	ETHEL STANLEY  ral Route Number, City or Town, State, Zip Code)
	nd 2 still ar lith ar 27 is		LAWRENCE O. GORDON (SON) 21	488 PRATHER DRIVE, L	EXINGTON PARK, MD.,20653
Baltimore,	Pages 1 arment of Heannot It item ant: If item ury or othe		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Removal from State  `4 □ Donation 5 □ Other (Specify)	y, crematory or other place)	Date 20c. Location - City or Town, State 9-2004 ALAMO, TENNESSEE, 38001
Balt	permit. Pages Department of I Important: If ite any Injury or or onca.		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility RUCK TOWSON FUNERAL	HOME, INC. 1050 YORK ROAD TOWSON, MD. 21204
	Ohyoioian		23a. Part1. Erner the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  METASTATI  Due to (or as a consequence of		1 WEEK
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	
30,	icate be executed physician and s the burial-transit	i Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):	
68760,	rtificate b ng physic as the b	Medicai	IF FEMALE:		
О. Вох	at the death certific by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes  XNo 9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
s, P	signed d be de	leted by Pł	Part II. Other significant conditions contributing to death but not resulting in DIABETES MELLITUS	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably *** Unknown
Record	The law requate has been page 2 shoul	ошо			24a. Was an autopsy performed?  1 ☐ Yes ▼▼No 1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	o Be C	25. Was case referred to medical examiner?  1  Yes  YY No	Other	th (Check only one)_ ome 5 ☐ Residence 6 ☐ Other (Specify)
	ng fter	tlon: T	27. Manner of Death 28a. Date of Injury 28b. T	ime of a 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
Division	al or Attending s after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ner ner	edical C	29a. Certifier (Check only one)    Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check only one)   Check one)   Check only one)   Check only one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check	death occurred at the time, date and place, d/or investigation, in my opinion, death occur	, and due to the cause(s) and manner as stated.  rred at the time, date and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier  Market U. D	29c. License number D 47945	29d. Date signed (Month, Day, Year) SEPTEMBER 4, 2004
į	10		30. Name and address of person who completed cause of death (Item 23a) (		21204
	Sta Regista		HARIS ALLEN, M.D., 7505 OSLER DRI  31. Date filed (Month, Day, Year)  SEP 0.7 2004	Sports	,, LILUT

State of Maryland / Department of Health and Mental Hygiene

				Otate of It	nai yiai	•			Death		leg. No.?   (	71.	2011	0
			1. Decedent's Name (First, Middle, Las	t)						2. Date of Dee		J 14	3. Time of Death	J
	Physician /Medical		BEVERLY J.	ARRING	GTON					AUGUST		Year )4	1:15 AM	
	Examiner		4a Fecility Name (If not institution, give	street end numbe	r)			-	b. City, Town, or	Location of Death	4c. County	of Death		
			LARKIN CHASE N	URSING HO	OME				BOWI	E	PRINCE	E GEO	ORGE'S	
	Funeral	1	5. Social Security Number 6. Se	9x 7./ □M 2√3 F		lest birthday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 952	9. Birthp	place (State or Forei	gn
8	Director		401-70-0704	□ w 2Q(F	52	Yrs.				February		Kent	ucky	
	pu &	-	Usuel Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation					1	Od. Inside City Limit	te
	show that		MD Prince (	Correcta	100.01			<b>.</b>				'	11∑ Yes 2 □ N	
	Ba-f Mark	<b>É</b>  -		seorge s		Cotta					10. 02	// C	TT 11	
	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23a or 28a-f show but, the Mazical Exerciner must be notified at a Completed by Funeral Director	5	10e. Street end Number				10f. Zip				I0g. Citizen of W		itry?	
	ath age	<u> </u>	4142 Bunker HI			C 12 V		0722		nacity Vac or No.	U.S.A		can Indian,	
	in the man de	5	11. Maritel Status	12. Was Deceder Armed Forces	s?	, S. 13. V	f Yes, spec	ify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black	k, White,		
20	rs aft		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates		1	I□ Yes 2	2⊠ No	Specify:		Specify:			
21215-0020	uld be filed within 72 hours a Mantel Hygiena. Irked other than "natural", or itic event, the Marical Exam. To Be Completed by	<b>.</b>	15. Decedent's Ed		-	16a. Deced	lent's Usua	I Occup	ation		16b. Kind of Bu	BL/		
15	in 72		(Specify only highest gree	de completed)		(Give	kind of wor	k done e retired	during most of wor	rking	TOD. THIS OF DO	J	2001.)	
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Maryland	shou and M mark		19a. Informant's Name/Relationship (7	ype, Print)	_	19b. Mailin	g Address	(Street	and Number or Ru	irel Route Numbe	r, City or Town,	Stete, Zip	Code)	
ž	lith and 27 is 27 is ritrat	1	Norris Porter/N	lother									ky 40212	
<u>a</u>	tem tem		20a. Method of Disposition		20b. F	Place of Dispos cemetery, cren				Date	20c. Location - 6			_
10	ages ant of tr: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stat	0	iverdal			l l	8/24/04	Pinorde 1	o Mr	revland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylen Department of Health and Mantel Hygiena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any houry or other treumetic event, the Marical Examiner must be noticed at any loury or other treumetic event, the Marical Examiner must be noticed any once.  To Be Completed by Funeral Director	-	21. Signature of Funeral Service Licens		IX.	22	. Name an	d Addre	ss of Fecility J.	D Tau-1	i r	e, ma	Tyranu	_
Ba	permi Depa Impo any Ir		N N II	1.11		7/	7/ Ta		. ا - ا موجود	b. Jenk	ins fu	nera.	1 Home	
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			23a. Part1. Enter the disease, or comp shock, or heart feilure. List only	one cause on eech	line.	n. Do not ente	er the mode	e or ayın	g, such as cardiad	or respiratory an	est,	1	Approximate Interval Between Onset and Death	
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	Examiner		disease or condition resulting in death)	a. 1)	1/12	20116		KY	cert	(an 1			X/5_	
н	in the second				Due to (d	or as a conseq	uence of):					1		
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Records,	uires the signer of the d									24a. Was a	in autopsy	24b. W	ere autopsy findings	3
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a			05.144							1UY		11.	☐Yes 2☐ No	-
Vital	Physician: this certific ral director.		25. Was case referred to medical examiner?	Hospital:				Oth	or /	ath (Check only or		40		
of	this raid raid	1	1 ☐ Yes 2 ☑ No 27. Menney of Death			ER/Outpatien 28b. Time of		_		lome 5 Resid	ence 6 ⊟Othe ow injury occurre		у)	=
o	After fune		1 ☑Neturel 5 ☐ Pending	28a. Date of In (Month, L	ey Year)	Injury	м	8c. Injur Wor 1 □	k? Yes 2∐No		,			
5	Attending in death.  Sctor: After by the fune		3 Suicide 6 Could not be		niury - At h	ome farm stre	eet factory			28f. Location (S	treet and Numbe	er or Rura	al Route Number,	_
Division	tal or Attending P is after death.  In Director: After the fine of in by the funers  Certification:		4 ☐ Homicide determined	building,	etc. (Specif	<i>y)</i>	oot, Idotory	, 000		City or Tow				
_	To the Hospital or Attending Phys within 24 hours attar death. To the Funeral Director: After this completally filled in by the funeral di Medical Certification: To Medical Certification: To	+	29a. Certifier 1.2 Certifying Phy	rsician: To the bes	t of my kno	wledge, death	occurred :	at the tin	ne, date and place	and due to the c	ause(s) and mar	nner as s	tated.	_
	in 24 hour he Funer pletaly fill edical		(Check only 2 Medical Exam		of examina									
	vithin of the omple		29b. Signature and title of certifier				29c	. Licens	e number	, 2	9d. Date signed	(Month,	Day, Year)	_
	- 5 - 0		Nild				1	36	1971		8-5	21-	2004	
		1.	30. Name and odress of person who	amplefed cause of	death (Man	n 23e) /Tuno 1	Print)		., 0	0.	10		1	1
	(R/2)	1	A LA CALL	Carl w	1200	V AA	<b>\</b>	40	ou mi	(h.) W)	Le Rd	. 3	2004 Somle M	
	State		31. Dete filed (Month, Day, Year)	0	trer's Signe	eture	J ,						20116	
*	State		- AUG 2 4 2004	1900	K	hour	20							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

			otate of Maryland,	Certificate of Death	Re	g. N⊕ ∏ ∏	29111
	Physici		Decedent's Neme (First, Middle, Last)     Corinne Boyd		2. Dete of Deet August		4:50am
)	/Medic Examin	.A.	4a Fecility Neme (If not institution, give street end number) Homewood Nursing Home		msport	4c. County of Death Washing	ton
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	birthday) If Under 1 Year If Under 24 H Months Deys Hours M	s. Date of Birth in. Month, Day, July 4	9. Birth Cou	place (State or Foreign ntry) D
	Marylend a-f show	tor		own or Location Liamsport			10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23a or 28	Funeral Director	10e. Street end Number 16505 Virginia Ave.	10f. Zip Code 21795	10	U.S.A.	ntry?
020	filed within 72 hours after death with the Marylend Hyglene. ther than "natural", or fleme 23a or 28a-f show thit, the Medical Examiner must be notified at	þ	11. Merital Status  1 □ Never Merried 2 □ Married  3 □ Was Decedent Ever in U,S.  Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pu  1 ☐ Yes 2 ☐ Specify:		14. Race - Ameri Black, White, Specify: Wh	
21215-0020	within 72 h lene. than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grede completed)  16. Telementary/Secondary (0-12) College (1-4or 5+) 12th grade 4 years	Sa. Decedent's Usuel Occupation (Give kind of work done during most of w life. DO NOT use retired)  Homemaker	vorking	16b. Kind of Business/In residenc	
	should be filed withir and Mentel Hygiene.  merked other than umatic event, the Mi	To Be Co	17. Father's Name (First, Middle, Last) Samuel Troupe		lame (First, Middle, M ence Bre		
Maryland	nd 2 shou alth end M 27 la mar r traumat			9b. Mailing Address (Street and Number or B80 Green Bay Rd.		City or Town, State, Zipa, Ill 60	093
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mantel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mance.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	of Disposition (Name of Augus lay, crematory of other place) Asburg Crematory	2004 2004	20c. Location - City or To Smithsbur	
Balt	permit. Depertr Importa any inje		21. Signature of Funeral Service Licensee	22. Name and Address of Fecility Donald Edwin T P.O.BOX 310 Cl	ear Spri	ng, MD 21	ome, Inc 722
	Physician /Medical Examiner	er .	23a. Part 1. Enter the disease, of complications that caused the death. D shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  a.	o not enter the mode of dying, such as cerd  UUTN (T7CN)  a copsequence of):	liac or respiratory arre	Ma _k	Approximete Interval Between Onset and Death
k 68760,	death certificate be axecuted e attending physicien and od for use as the burial-transit	Physician/Medical Examiner	if enty, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	a consequence of):  a consequence of):  a consequence of):	WTA	(	terns
Вох	eath cer attendin I for use	clan/					
, P.O.	v requiras that tha de been signed by the s should be detached	by Physi	Part II. Other significant conditions contributing to death but not resulting  WEMPHEAST UAGCUCAN	DUS ACC	23b. Did tol	becco use contribute t es 2 No 3 □ Pro	bably 4 🗆 Unknown
Records,	The taw requiras that tha ata has been signed by th page 2 should be detach	Completed b	CHAUNCE RENAR LAGO	tenay	24a. Was ar perform	ned? av	ere autopsy findings ailable prior to impletion of cause death?
a R					1 □ Ye		☐Yes 2☐ No
Vital	Physician: The ribis certificata rail director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/	Other: a	Death <i>(Check only one</i> Thome 5 ☐ Reside	e) nce 6 □Other (Specia	(v)
0	Attending Physic death.  • ctor: After this by the funeral di	ation: T		b. Time of linjury et Work?  M 1 Yes 2 No		w injury occurred	,
Division	를 다 들	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At nome, building, etc. (Specify)	farm, street, factory, office	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
	To the Hospital within 24 hours of To the Funeral complately filled	edicai	29a. Certifier (Check only one)  1. V Certifying Physician: To the best of my knowled end manner stated.  29a. Certifier (Check only one)  1. V Certifying Physician: To the best of my knowled end manner stated.	ge, deeth occurred et the time, date end pla and/or investigation, in my opinion, death oc	ace, and due to the ca ecurred at the time, da	use(s) and manner as s ate and place, and due to	tated. o the cause(s)
	To the To the	Me	29b. Signature agentile of Commigr	29c. Eicense number	25	Accessioned (Month,	Dey, Yeer)
~ h	13		30. Name and eddress of person who completed cause of deeth (Item 28)	a) (Type, Print)	ALE HA	7565 T70 ml	Ind
	Sta	ite	31. Dete filed (Month) Di GYer) 4 2004 32. Régistrers Signature	A. M.	1-11	5/7/13	

			- Tougo 1	State of Marylan				Mental Hyg		egibic.	
			1 - For State Registrar			rtificate of			eg. No.	004	28112
П	Physici		1. Decedent's Name (First, Middle, Last)		·			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Jacob Kreider Bai					Augu		20 200	1
	Examin	er	4a. Facility Name (If not institution, give s			Hagersto	or Location of Deatl	h		County of Death Ishinata	n County
-	Funeral		Washington County 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign intry)
	Director		214-09-4045	^{M 2□ F} 96	Yrs.	Months Days	Hours Min.	Feb. 1	) <b>,</b> 19	08 Peni	nsylvania
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Maryla f eho	Į0									1 ☐Yes 2 ☐ No
	r 28a	Director	Maryland Washington 10e. Street and Number	on co. nage	erstow	10f. Zip Code			0g. Citiz	zen of What Cou	intry?
	death with the Maryland ims 23a or 28a-f ehow	al D	1115 Hamilton Blvd	•		21742			U.S.	.A.	
	er dea	Funeral	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>	
50	hours after urel', or Ite al Εχαπάτα	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ∑No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify: โฟ	hite
3-003p	I within 72 hours after death with the Marylan ion. ion. Itah. "naturel", or Items 23a or 28a-1 show the Medical Examiner must be notified at	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	pation	rking	16b. Kin	nd of Business/I	
Ž	within 7 ene. than *r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	l		during most of wor	Ning	Jewe	elery St	ore
7	ited w Hygier ther th		17. Father's Name (First, Middle, Last)	2	watch	Maker/		ne (First, Middle,			
land	d be f ental l	To Be	F. Ross Bare				AnnaKre				
>	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Numbe	r, City or	Town, State, Zi	ip Code)
, Ma	1 and 2 Health a iem 27 ls		Louise F. Bare /	Wife	_		Blvd. Ha				4
Baitimore,			20a. Method of Disposition 1 → Burial 2 → Cremation 3 → R	emovai from State		sition (Name of matory or other pla	4	Date		cation - City or T	
	t. Pa rtmen rtent: njury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Re	The second second	en Cemeto 2. Name and Addre		24, 2004	Ha	gerstov	wn, Maryland
a C	permit. Page Department of Importent: If eny injury or once.		21. Signatore of Funeral Service License	1 Finis	Ē	ouglas A	. Fiery F ern Blvd.	Tuneral H	lome	NATIONAL TRANS	21742
	W 25	1	23a. Part1. Enter the please, or complishock, or heart lailure. List only or	cations hat caused the deatl						JWII, PRO	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cause on each line.							Onset and Death
,	/Medical		resulting in death)	Due to (or as a consequence	uence of):		neut how				3 MINGES
	Examiner	_	Sequentially list conditions,	Due to (or as a consen	0 ( C ~	(sel I	h farthe				10 minutes
	ted nsit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq.	derice or,.						
<u> </u>	ate be executed hysician and he burial-transit	Еха	resulting in death) Last	Due to (or as a conseq	uence of):						
3/60	ate be nysicia he bu	Icai		i							
õ ×	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	1001						
X R O	eath certific attending pl	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	I death 3[	Ectopic pregnanc	ÿ		2	3d. Date of deliving Month	Day Year
o.	by the a	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown							
S,	The law requires that the tite has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	inderlying cause gr	ven in Part I.	23e. Did to			the cause of death?
g	w require been si should b							1 U Y	es 2	gNo 3∏Pro	bably 4 Unknown
Records,	e law i has b	Completed						24a. Was a autop	SV	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
_								1 ☐ Yes	2 2 No	1 🗆 Yes	2 □ No
Vital	yaician: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2 I	ER/Outpatie	nt 3□ DOA Ott	hon	ath <i>(Check only or</i> dome 5 ☐ Resid		Other (Spec	(6.1)
0	ding Phy n. After this funeral d	1-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe h			(y)
Š	tendin death. tor: Aft the fur	atlo	1 ②Natural 5 ☐ Pending investigation	(Month, Day Your)	iii,ai y		Yes 2 □No				
Division	or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (S City or Tow			al Route Number,
	pitel ours a eral D		29a. Certifier 1 Certifying Phy	sicien: To the best of my kno	wledge deal	h occurred at the t	ime, date and place	and due to the o	ause(s)	and manner as	etated
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical		ner: On the basis of examina and manner stated.							
	To th within To th compl	Me	29b. Signature and title of certifier				se number			signed (Month,	
)	\~s		Michael O	Mulan	no	2 6	4166	7	E	3/20/0	04
:-	JH-11 th		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,	Print)	(my 05)	11 14	A.A -	. 2.	MO
	Sta	ite.	31. Date filed (Month, Paps Year) A 70	32. Begistrar's Signa	ature	1 .1.	Commos	0/2	Ser	Jiwa	1011.
*	34 D.		AUG 64 A	104 Baccas	1. 1. A.	DENGER					

ICHARD VERNON BUIZZARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 Richard Vernon Blizzard August 2004 2126 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№**М 2□ F Months Days Hours Min. Yrs. Director 64 05 1939 <u>215-36-8183</u> Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at MD Carrol1 New Windsor 1 ☐ Yes 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1851 Dennings Road 21776 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: Be Completed by lf Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Retail item 27 is marked other other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) A. Vernon Blizzard Edna Dell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 8 1851 Dennings Road New Windsor, MD Bonnie Blizzard/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 8/2072004 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If eny injury or once. Evergreen Memorial Gardens 5 ☐ Other (Specify) Finksburg, MD 4 Donation Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a Part1/Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Severe CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣No 1 Yes To the Hospitel or Attending Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier WIL 17/04 023015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 D.S.KALARIA 217 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004

Amended Item 23a, Part I per Physician 08/19/2004 Carroll County, wjl

			For	State of Marylar	nd / Dep	artment	of He	ealth a	nd Me	ental Hyg	giene	e	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	•		1 - State 8-30-04 Registrar Amend #'s 17.	& 18.Per Informt.	PGC Ce	rtificate	of D	eath			Reg. No	200	1	28114
đ	Physici	an	Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	ath Day	y	Year	3. Time of Death
	/Medic	al	Rita Elizabeth  4a. Facility Name (If not institution, give	Blair		4b. City, T	oum or I	ocation of		August		200 County of		7:45 p M
	Examin	ier	Quail Run Assiste	· ·			fton		Dealli			Anne		do1
	Funeral		5. Social Security Number 6. So	7. Age (In yrs.	last birthday)	If Under 1		If Under 2	24 Hrs.	B. Date of Birt (Month, Day				place (State or Foreign
	Director		Usual Residence of Decedent	□M 2ŽŠF 88	Yrs.	I I I I I I I I I I I I I I I I I I I	Days	110013		June 26	5, 1	916	Mass	achusetts
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							1	0d. tnside City Limits
	a-f sh	ctor	Maryland Anne Aru	ndel Gam	brills	3								1 □Yes 2XNo
	or 28	Director	10e. Street and Number			10f. Zip C						izen of W	hat Cour	ntry?
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Evaminet must be notified at	erai	2163 Davidsonvill	e Koad  12. Was Decedent Ever in U	C 12	210		nania Oria	in? /Cno.		U.S.		Amorio	an Indian,
(0	r Item	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No					Puerto R	ify Yes or No- ican, etc.)			, White,	
903	ours a	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2]	<b>X</b> No	Specify:				Specify:	Whi	te
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12	within iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	_	etary	, ratirou,				Fed	dera1	Gov	vernment
p	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Evantiner must be notified at	BeC	17. Father's Name (First, Middle, Last)							(First, Middle,				
ylaı	should be find Mental if marked of	Tof	Charles Lineham	Charles Lineh	_					<del>ons</del> R				
Maryland 21215-0036	0 8 8	1	19a. Informant's Name/Relationship () Dorothy Nicholson							Route Numbe evensv				•
	s 1 and 2 of Health item 27 I		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name	e of	1	Da	-				wn, State
E O	Pages nent of thanks: If ite ant: If ite		1 X Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specify	Hemoval from State	cemetery, cre. surrec				08/18	3/2004	Cli	nton,	Mar	yland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service ricen	500	2:	2. Name and	Address	of Facility	Gas	ch's Fu	ıner	al H	ome,	P.A.
	205 29		23a. Part1. Enter the disease, or comp	MO137						, Hyatı		11e,	MD	
r			shock, or heart failure. List only	one cause on each line.			or aying,	, such as c	ardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aAlzheimer's		ntia							-	Years
	Examiner		Sequentially list conditions	b. Atheroscler		leart l	Dise	ase						Years
	pe lisi	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse.	uence of):									
	and and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	juence of):						-		-	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cai	· ·	d.										
9	ertifica ing ph e as th	ed	IF FEMALE:											
Вох	eath certific attending p I for use as t	ian/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	ıl déath 3	Ectopic pre						23d. Date Mont		ory Day Year
o	at the de by the a	Physician/M	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unknown		Other (spec	City)							
D,	es that igned b be deta	by Pl	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cau	use giver	n in Part I.		23e. Did to	bacco L	use contrib	oute to th	e cause of death?
ecords,	w require been sig should b									1 🗆 Y	es 2	X No 3	Prob	ably 4 Unknown
3ec	e law has be	Completed								24a. Was autop	SY	Dr	ere autor ior to cor ath?	psy findings available npletion of cause of
al B		e Col	25. Was case referred to medical					00.01			med? 2X No	1 [		2 No
Vital	yaic s ce direc	0	examiner?  1 \( \sum \) Yes 2 \( \overline{\lambda} \) No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Othor			(Check only o		6 □Other	(Specify	7)
n of		on: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury a Work?			3d. Describe h				,
Division	Attending r death.	ertification;	2 Accident investigation 3 Suicide 6 Could not be		0m o form at	M		es 2□N	-	of Location /S	'troot an	d Numba	os Guro	I Courte Aliverte e
Div	5 = c	ertif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)	reet, ractory,	OHICE		20	City or Tow	n, State	)	or Aura.	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the form of the filled in the form of the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the	edical C	(Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	owledge, deat	h occurred at	t the time	, date and nion, death	l place, an	nd due to the o	ause(s)	and man	ner as st	ated.
	To the I within 24 To the I complete	Med	one) 29b. Signature and title of certifier	and manner stated.			License							Day, Year)
	F 3 F 0		Ka Kes	4sh and	ono	D	2010	8			2	3/1	8/	04
^	0		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,									
0	1- (0)		Rakesh Arora, MD	14300 Gallan	t Fox	Lane,	Ste.	222	, Bov	vie, Ma	ry1	and 2	20715	5-4003
	Rakesh Arora, MD 14300 Gallant Fox Lane, Ste. 222, Bowie, Maryland 20715-4003  State Registrar  AUG 2 4 2004  Registrar's Signature  AUG 2 4 2004													

			••	ndelible ink. Ensure All Copies A	
			- For	partment of Health and Mental Hygi partificate of Death	2001 2011
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No. 3. Time of Death
	Physicia		Lee Chandler Bramble	Month	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	12, 2004 1336 "" 4c. County of Death
1	Examin		Chester River Hospital Center	Chestertown	Kent
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		9 Birthplace (State or Foreign
	Director		215-20-0828 ¹ M 2□ F 78 Yrs.	03/15/19:	26 Maryland
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Manyla I sho	ō	Maryland Kent Millin		tv∑Yes 2 No
	28e-1	Directo	10e. Street and Number		g. Citizen of What Country?
	3a or	٥	342 Cypress Street	21651	USA
	death ms 2	Funeral		. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
9	after or ite		1 Never Married 2 Married 1 1 Yes 2 No	1 Yes 2 No Specify:	Black, White, etc.
93	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow Jigal Evaniber must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: White
21215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	6b. Kind of Business/Industry
12	within sene.	dmc	Elementary/Secondary (0-12) College (1-4or 5+)		There were a section to it is an
	filed Hygid Sther ent, I	O	17. Father's Name (First, Middle, Last)	wner/operator 18. Mother's Name (First, Middle, M	Transportation  [saiden Surname]
lan	Mental Mental arked o	To B	Nathaniel Samuel Bramble	Mary Alice Baile	У
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, Ita Ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Addrass (Street and Number or Rural Route Number,	City or Town, State, Zip Code)
	1 and 2 Health am 27 in			Cypress STreet, Millington	·
ore	S to the		20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State	ematory or other place)	Oc. Location - City or Town, State
altimore,	nit. Pag artment ortent: injury (		`4 Donation 5 Other (Specify) Asbury C		illington, Maryland
Bai	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Ellows, Helfenbein & Newnar	m Funeral Home, P.A.
	do z e d		233 Part 1. Enter the disease, or complications that caused the death. Do not en	70 W. Cypress STreet, Mill:	ington, MD 21651
			Snock, or near failure. List only one cause on each line.	2151	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  a. Hour Plan rate  Due to (or as a consequence of):	my Distuss Syndrome	5day 5
	Examiner		Preumonice	/	60095
	THE RE	ner	if any leading to immediate Due to (or as a consequence of):	0 .	10.
	icuted nd transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events  c. A greation v =	, Vseudommos	68645
60,	e be executed rsician and e burial-transit	Ē	resulting in death) Last Due to (or as a consequence of):		
687	physic the b	dicai	d		
9 X	certifi iding ise as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	atter I for u	ciar	23b. was decedent pregnant 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.O.	the d by the achec	hysi	9 Unknown		
	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did toba	acco use contribute to the cause of death?
of Vital Records,	w require been sig should b	edt	Var linson's Disease	1 Yes	s 2,5No 3 Probably 4 □Unknown
BCC	law re as be 2 sho	plet	Lung Concer	24a. Was an autopsy	prior to completion of cause of
Œ	The ate h page	Completed	O .	perform 1 ☐ Yes 2	death?
/ita	cian: ertific	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one	)
of	Physician: this certific ral director,	70	1   Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatin  27. Manner of Death 28a. Date of Injury 28b. Time		
n C	ding Physician: The lav h. After this certificate has funeral director, page 2	lon	1 Natural 5 Pending (Month, Day Year) Injury		winjury occurred
Division	death death ctor: y the	fical	3 Suicide 6 Could not be	street, factory, office 28f. Location (Stre	eet and Number or Rural Route Number,
Ö	after Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier Check only 2 Medical Examiner: On the best of my knowledge, dea		
	in 24 he Fu he Fu pletel	Medical	one) and manner stated.		
	To h	Σ	29b. Signature and title of certifier	29c. License number 29	d. Date signed (Month, Day, Year)
,			Am Khos mis	D17036 Md 8	1113104
			30. Name and address of person who completed cause of death (Item 23a) (Type Susan C Ress MD 5/6 Washington	of Are Clostnown Mel 5	2/620
	Sta	te	31, Date filed (Month, Day, Year) 32. Figistrar's Signature		
	Registr		AUG 1 6 2004 Access 15	book	

			1 - For State Registrar		State of	f Marylan	•	artment rtificate			ınd Me	, ,	iene	nnL	281	16
			Decedent's Name (First	st, Middle, Las	t)						1	2. Date of Deat	th	004	3. Time of I	Death
н	Physici		GERALD LE	ON E	AKER						A	UGUST	26	2004	11:10	РМ
	/Medic Examin		4a. Facility Name (If not in			nber)	-	4b. City,	Town, or l	ocation o				ounty of Deat		
н			8324 BARNES	ROAD					BOON	SBOR	0			WASHIN	IGTON	
	Funeral		5. Social Security Number			7. Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day,	Year)	9. Birt	hpiace (State or	Foreign
	Director		218-40-3874	ł	XIM 2□F	61	Yrs.				N	OV. 11	, 194	42 M/	ARÝLAND	
	and w		Usual Residence of Dece 10a, State 10b.	dent County		10c. Cit	y, Town or Lo	cation							10d. Inside City	y Limits
	Aary!	៦	MARYLAND W	VASHING	TON				DOOM.	SBOR	$\cap$				1 □Yes	2 📉 No
	28a-	ect	10e. Street and Number	VASILING	TON			10f. Zip		DDOM	0	1	0g. Citize	en of What Co	untry?	
	a or	Funeral Director	8324 BARNES	S ROAD						713				II.S	5.A.	
	death ms 2	era	11. Marital Status	ROILD	12. Was Dece	dent Ever in U	.S. 13.	Was Deced			in? (Spec	ify Yes or No- ican, etc.)	14	4. Race - Ame	rican Indian,	
9	or Ite		1 Never Married	2🔯 Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 X No	ł	17es,spec 1⊡Yes 2		, Mexican Specify:	, Риепо н	ican, etc.)		Black, White	e, etc.	
93	ral', c	1 by	3 ☐ Widowed 4 ☐ [	Divorced	Year or D			1 195 2	ZIMI INO	зреспу.			3	Specify:	WHITE	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-1 show is Medical Exartirer must be notified at	Completed		Decedent's Ed Bly highest gra	lucation de completed)		(Give	dent's Usua kind of wor	rk done du	ion <i>Iring most</i>	of working	7	16b. Kind	d of Business/	Industry	
121	within ane. than	ם	Elementary/Secondary	(0-12)	College (1	-4or 5+)		do not us SERVIO		ים בוכודי	VISOR		CODE	O ECTITON	NAL FACI	יייד דייע
	Hygie Hygie ther	ပိ	17. Father's Name (First,	Middle, Last)				OTTV ATC				First, Middle, I			VAL L'ACI	.11111
Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	PAUL LEON F						G	ERAL	DINE	LAURET	CA BO	OND		
<u></u>	shoul nd M mar	-	19a. Informant's Name/F		Type, Print)		19b. Maili	ng Address		-		Route Number			Zip Code)	
	nd 2 alth a 27 is	11	TERRACE J.	BAKER/	SPOUSE		8324	BARNI	ES RO	AD,	BOONS	BORO, 1	MARYI	LAND 2	21713	
Baltimore,	s 1 a of He item othe		20a. Method of Disposition			_	Place of Dispo	sition (Nam	ne of ther place	)	Da	te	20c. Loca	ation - City or	Town, State	
E	Page nent c int: If		1 ⊠ Burial 2 □ Cre 1				EVOLA :	IJ.M. (	CEMET	ERY	8/30/	2004	BOONS	SEORO.	MARYLAN	ID
alti	permit. Departn Imports any inju		21. Signature of Funeral	Service Lider			22	. Name an	d Address	of Facility	у -	7606 01		-		
<b>B</b>	89 = 89		aux	1 Ale	w	ıl m. De		AST F		17.3	1	odanoos		Marylar	d 2171	.3
			23a. Part1. Enter the dis	se se, or com ure. List only	olications that cone cause on e	aused the deat ach line.	h. Do not ent	er the mode	e of dying.	, such as	cardiac or	respiratory arre	est,		Approximate Interval Betw Onset and D	reen
	Physician		Immediate Cause (Final disease or condition	100	а.	(0	lon	Car	nec	_					0 -	シュた
	/Medical Examiner		resulting in death)	(	Due to	or as a conseq	uence of):									
		Į,	Sequentially list condition	ns,	b. Due to	or as a conseq	uence of):									
121	uted J unsit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying that initiated events	_ <												
Ć.	exection and and rial-tra	Exa	resulting in death) Last	1	Due to (	or as a conseq	uence of):						•			
8760,	cate be executed physician and the burial-transit	dical		•	d											
9	ntifica ing ph	l w	IF FEMALE:									-				
Box	death certifi e attending   d for use as	an/	23b. Was decedent preg		1 Live b	come of pregna irth 2 - Feta	I death 3	Ectopic pro					23	ld. Date of deli Month	-	ear
_	res that the death certifications to the attending I be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregn 9□Unkn	ant at time of down	leath 5	Other (sp	ecify)						,	
P.0	that the	Ph	Part II. Other significant	conditions	ontributing to de	eath but not res	ulting in the u	nderlying ca	ause giver	n in Part I.		23e. Did tob	pacco use	e contribute to	the cause of de	ath?
ds,	requires that een signed b nould be deta	d by										1 🗆 Ye	s 2 🗹	No 3□Pro	obabiy 4 🗆 Ur	nknown
So	> 9 10	ete										24a. Was a	n	24b. Were au	topsy findings a	vailable
Vital Records,	The law ate has page 2 s	Completed										autops perform	ned?	prior to death?	completion of cal 2 ☐ No	use of
ta	sician: Th certificate rector, pag	Be C	25. Was case referred to	medical	<del> </del>					26. Place	of Death	1 ☐ Yes 2 Check only on	e)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	21110	
Ξ	S .0 5	0	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 🗆 I	npatient 2	ER/Outpatier	nt 3□ DO	Other	4 🗆 Nui	rsing Hom	e 5 🏋 Reside	ence 6[	□Other (Spec	cify)	
J of	ig Ph ter th neral	n: T	27. Manner of Death	Pending	28a. Date	of Injury th, Day Year)	28b. Time o	f 2	8c. Injury Work	at ?		d. Describe ho				
Ö	endir sath. or: Af	atlc	2 Accident	investigation	1			М		es 2 🗆 î						
Division	or Att ter de lirecte n by t	Certification;	3 Suicide 6 L 4 Homicide	Could not b determined	200. Place	of Injury - At he ng, etc. (Specif	ome, farm, sti fy)	eet, factory	r, office		28	If. Location (St City or Town	reet and i n, State)	Number or Ru	ral Route Numb	er,
٥	pital curs af	Ce	20-0-15	Cartifulna Dh	ysician: To the	book of my lead	ladaa daat			doto on	d place, or	d due to the ea	(a) -		-	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical			niner: On the b											
	othe vithin othe	Me	29b. Signature and title of	of certifier				29c	. License	number		2	9d. Date	signed (Month	n, Day, Year)	
			1 Ami	elevel	9.0	relu	M.	0	0	416	67		8	2.27	104	
	014-12		30. Name and address of	of person who				Print)		-						
9	Oly		Miche	el D		ornett		1110	N	edie	1 6	mpics	1/2,17	estou	~ WP	
	Sta Regist		31. Date filed (Month, D	G 27 2	004 32.	egistrar's Signa	d. A.	nertes	,				•			
	-					- TITLE										

Amended Item 26 per Physician 08/18/2004 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryla	•	artment of I rtificate of		F	Reg. No. () ()	28117
	Physici		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin	ai -	Irene Lee Bower 4a. Facility Name (If not institution, giv			4b. City, Town, o			4c. County of Dea	
	Funeral		Carroll Hospital 5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Under 1 Year		24 Hrs. 8. Date of Birt	Carro	DII thplace (State or Foreign ountry)
	Director		220 22 3003	□ M 2 🔀 F 8	3 Yrs.	Months Days	Hours	Min. (Month, Da)	1920	VA
	ow ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation			.,	10d. Inside City Limits
	e Mary	ctor	MD Carro	)11	Westr	minster				1 ☐ Yes 2 ☑No
	h with th	ai Director	10e. Street and Number 419 Hook Road			10f. Zip Code 211	.57		10g. Citizen of What Co USA	ountry?
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28a-f show the Mailcal Exemiter must be maiffed at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		gin? (Specify Yes or No , Puerto Rican, etc.)		
5-0	72 hours "natural", alcal Exp	eted	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occu	during most	of working	16b. Kind of Business	Andustry
21215-0036	t within 72 ho piene. r than "natur the Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire  Owner/Ope			Hairdres	sser
Maryland 2	be filed ital Hygi of other event, I	To Be Co	17. Father's Name (First, Middle, Last Leonard Carl Depe					r's Name (First, Middle, Mae Shell	Maiden Sumame)	
lary	d 2 should It and Men 7 Is marke troumatic		19a. Informant's Name/Relationship (	Type, Print)					er, City or Town, State,	
	s 1 and of Health item 27 other tr		Jayson Carl Bower			Clearvie osition (Name of matory or other pla		Union Brid	ge, MD 21.  20c. Location - City or	
nor	0 0		1 ☐ Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	JHemovai irom State		matory or other pla ranch Cem		3/19/2004	Westminst	
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Lice	ns e	P	2. Name and Addr ritts Fur	ess of Facility neral I	Home and Ch	apel, P.A.	21157
			23a. Part1. Enter the disease, or corr shock, or heart failure. List only	pplications that caused the de	ath. Do not en	12 Washir ter the mode of dy	ing, such as	Road Westm cardiac or respiratory ar	inster, MD	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Chroni	col	struct.	Tie Ti	Immau	disiaro-	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dua to (or as a conse	equence of):					
,092	death certificate be executed e attending physician and ed for use as the burial-transit	ical Examiner	that initiated events 'resulting in death) Last	Due to (or as a conse	equence of):					
89	g phys			0.						
O. Box	that the death certifical ted by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 3 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of de Month	livery Day Year
<b>a</b>	es that tigned by	by Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause g	iven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ords	w require been sig should b	ted b	_ Gastric	ulcesE	G-I	bleader	سع ما	wy 04 10	Yes 2 No 3□P	robably 4 Dunknown
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed					<u> </u>	24a. Was autor perfo 1 \( \text{Yes}	an 24b. Were a prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
Vital	icien: certific	Be	25. Was case referred to medical examiner?	Hospital:	<b>T</b> 500	4 85 804 01	than	of Death (Check only o	, CRA	watel Living
of	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	tlon; To	1 ☐ Yes SNo  27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ZER/Outpatie 28b. Time Injury	of 28c. Inju	4 L. Nu		how injury occurred	
Division	or Atten after deal Directors d in by the	Certification;	3 Suicide 6 Could not l	be Diago of Injury - At		treet, factory, office	•	28f. Location (. City or Tou	Street and Number or R wn, State)	ural Route Number,
	e Hospita 24 hours e Funere letely fille	edical C	29a. Certifier (Check only one)  Certifying P  2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the to	time, date an	d place, and due to the th occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and the of certifier			29c. Licen	se number		29d. Date signed (Mon.	th, Day, Year)
	WILL		1	arico fe 1	ND		000	906	08/15/0	04-
	May		30. Name and address of person who	completed cause of death (II	951	), Print)	Joh	Ralling	on Dridg	M21791
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32, Registrar's Sig	nature	how.			O	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ΑM Claudia Deann Brinker 2004 0650 August 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 57 Arundel Lane Elkton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea AUG 26, 19 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Director 63 170-34-0911 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rei', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Cecil Elkton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 57 Arundel Lane 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No δ Specify: 3 Widowed 4 Divorced White naturel Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Vice President Banking Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other toury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Cribbs Brinker ည Elizabeth McKee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a cortent: If item 27 is injury or other train Carol J. Scheff/Friend 57 Arundel Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Greensburg, * 4 ☐ Donation 5 ☐ Other (Specify) Clair Cemetery 4, 2004 Pennsylvania 22 Name and Address of Facility
Hicks Home for Funerals, P.A. permit.
Departn
importe
eny inju 21. Signature of Funeral Service License 103 W. Stockton Street, Elkton, Maryland 2192 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Immediate Cause (Final disease or condition resulting in death) **Physician** reeser /Medical Due to (or as a consequence of): Examiner Mele Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter detached for u 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 0 1 🗌 Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate has birector, page 2 s was a.. autopsy performed? Yes 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death, ∠□ Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) clell Hon HD 301 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIH MD HSU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Cynthia Bagarus 04-05470 LCS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

054	170		1 - For Amend Item #2 Striper Many and 1298	parmastofrigath and de	gggtaglylygig Reg.	
	Physici	an	Decedent's Name (First, Middle, Last)			3. Time of Death Day Year
	/Medic		Cynthia M. B	<del></del>	August	24 2004 9:58 PM
4	Examin	ier	4a. Facility Name (If not institution, give street and number)  Shady, Grove Hooni + 2	4b. City, Town, or Location of Death  Rockville		4c. County of Death
	Funeval		Shady Grove Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgomery  9. Birthplace (State or Foreign Country)
3	Funeral Director		527-51-0178 1 M 2 DEF 46 Yrs	Months Days Hours Min.	(Month, Day, Ye Dec. 31,	1957 Arizona
3	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Leasting		10d. Inside City Limits
	ehov	5	W 1 1 2			1 ☐ Yes 2X No
	288-1	ecto	Maryland Montgomery Damascu  10e, Street and Number	10f. Zip Code	100	Citizen of What Country?
	Mith Ba or	ă		20872		nited States
	72 hours after death with the Maryland Instural', or Iteme 23a or 28a-f ehow dical Examiner must be notified at	Funeral Director	24213 Preakness Drive  11. Marital Status  12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
و	or ite	Ē	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	rican, etc.)	Black, White, etc.  Specify:
9	ural'.	d b	3 ☐ Widowed 4 Divorced Year or Dates:			White
21215-0036	"nate	Completed by	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	ring 16t	b. Kind of Business/Industry
12	withii iene. than	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk		etail Store
	Hyg Hyg other	a	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	
ılar	uld be Menta rked ric ev	To B	James Godwin	Dorothy	Gau	
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run	al Route Number, Ci	ity or Town, State, Zip Code)
3, ₹	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.			13 Preakness Drive,	Damascus Date 200	Maryland 20872 Location - City or Town, State
Baltimore,	ges 1 If of H or of		1 Burial 2 Cremation 3 Removal from State	rematory or other place)		c. Location - City or Town, State
Hi H	rtmen rtmen rtent: njury		*4 □ Donation 5 □ Other (Specify) All Soul  21. Signature of Funeral Service Licensee	s Cemetery 8/30	/2004 G	ermantown, Maryland
Ba	Deparimbe Impo any ir		bdd 2/1/mus	22 Name and Address of Facility Olin L. Molesworth 26401 Ridge Road,	P. A. Fu	neral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not shook, or heart failure. List only one clause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
8760,	eath certificate be executed  Exam  attending physician and for use as the burial-transit	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, any washing to man adate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ting Alcohol And Tr		
O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ω,		by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rd	w requires been sign should be				1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Records,	e law has b	Completed			24a. Was an autopsy performed	
/ita	Physicien: Th this certificete ral director, pag	Be (	25. Was case referred to medical examiner?		th (Check only one)	•
of	Physic this c	2	1 ∑Yes 2 □ No Hospital: 1 □ Inpatient 2 ☒ ER/Outp.  27. Manner of Death 28a. Date of Injury 28b. Tim		ome 5 Residence	e 6 Other (Specify)
on (	fter	Certification:	1 Natural 5 Pending Found Pay Year Form	e of 28c. Injury at Work?  PM 1 □ Yes XXNo		mary occurred
Division	uttendii death. ctor: A y the fu	ficat	0/24/2004	- 20	Unknown 28f. Location (Stree	t and Nymber of Rural Route Number. Dr.
Div	spital or At ours after o neref Direc filled in by	ert	3 Suicide 4 Homicide  6 Louid not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)  Hot Tub		Damascus.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus	e(s) and manner as stated
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifier  Zafráldal AS	29c. License number		Date signed (Month, Day, Year)
,			30. Name and address of person who completed gause of death (Item 23a) (Ty	O.C.M.E.	Al	ıgust 26, 2004
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Str	ceet, Balt	imore, Maryland 2120
	Regist	rar	SEP 0 7 2004 Denue	& loss.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 13, 2004 6:00 P.M Edward Gerard Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution, give street and number) Bradford Oaks Nursing and Examiner Prince Georges Clinton Rehabilitation Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Days Hours **Funeral** Months 76 312-22-0899 December 10, Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show the Medical Exertiner crust be notified at 1 ¥ Yes 2 □ No Directo Fort Washington Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 United States 8104 Barrett Road Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married ☐Yes 2X No Maryland 21215-0036 1 ☐ Yes 2X No Specify Black tf Yes, Give Year or Dates: 3 Widowed 4 Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Construction 2 years Painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental F tam 27 is marked of other traumatic ever Paris Bernice Toomer Edgar George Brown, I 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If Itam 27 ie eny injury or other trat once. 325 Emerson Street, N.W.; Washington, D. C. 20011 Gerard Lewis Brown (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 24, 2004 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Pert). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760, Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetet dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetet death Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **₽** Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 450No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 000 2 ER/Outpatient 3 DOA Certification: To 1 Tes 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pendina 102 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 701 Registrar's Signature 3 . Date filed (Month, Day, Year) State 2004 Registrar

			Please 1	ype or Print					-		_	
			For State Registrar	State of Ma	-	,	rtment of <i>ificate o</i> :		d Mental H	ygie: Reg.	2001	2812
			Decedent's Name (First, Middle, Last,	)					2. Date of D	eath	0.20	3. Time of Death
	Physici: /Medic	-	MARGIE E	BARKDOLL					Augus		Day Yeer , 2004	10:36 A
	Examin		4a. Fecifity Name (If not institution, give	street and number)			4b. City, Town	or Location of [			4c. County of Deat	h
			Prince George's Co				Chever	4			Prince Ge	
ć.	Funeral Director		5//-18-/128	M STE	(In yrs. last bir 34	thday) _ Yrs.	If Under 1 Year Months Day		Min. 8. Date of B (Month, I			hplace (State or Foreignitry)
	nyland show	_	Usuaf Residence of Decedent  10a. State 10b. County  MD Prince Geo	orne	10c. City, Town	n or Loc	ation					10d. Inside City Limit
	Ba-f s	cto	110	rgc	Largo		· · · · · · · · · · · · · · · · · · ·					1 ∑ Yes 2 □ N
	h with th	Funeral Director	10e. Street and Number 600 Largo Road				10f. Zip Code 20774				Citizen of What Co JSA	untry?
	deat	ner	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent o	Hispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ame	
036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel", or Items 23e or 28e-f show imatic event, the Medical Extender mark be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:			Yes 20XN		desto riican, etc.)		Specify: Wh	nite
ر د	72 h 'natu	etec	15. Decedent's Edu (Specify only highest grad		16a.	(Give k	ent's Usual Occ ind of work dor	e durina most o	f working	16b	. Kind of Business/	Industry
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altimore, Maryland 21215-0036	uld be file fental Hy rkad oth	To Be (	17. Father's Name (First, Middle, Last) William Henry New	ton					Name (First, Middle ie Jane H		,	
a	01 00 00 2		19a. Informant's Name/Relationship (T)	rpe, Print)	19b	. Mailing	Address (Stre	et and Number	or Rural Route Num	ber, Ci	ty or Town, State, 2	Tip Code)
Σ,	1 and 2 Health tem 27		Rosenary Mason/Guardia	in of Person			lentown	Road, Cam	p Springs,	MD 2	0748	
9	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	Removaf from State	cemeter	ry, crema	ition (Name of atory or other p	lace)	Date		. Location - City or	
	tmen tant: jury		`4 □ Donation 5 □ Other (Specify)	1 11	meuropo		n Cremato		3/14/2004		lexandria,	
E R R	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fuheral Service Licens	5. Pel	_	41	Name and Add	ress of Facility /Ivania Av	Cedar Hill /e., Suitlar	Fune nd, 1	ral Home,In VID 20746	ic.
	Physician /Medical Examiner		23a Pan1. Enter the disease, or compishors, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	_Cardia	ac A			rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a  Due to (or as a								
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death		Ectopic pregnar Other (specify)				23d. Date of deli	very Day Year
	res that isigned by	y Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in	n the und	derlying cause	given in Part I.	23e. Did	tobacc	co use contribute to	the cause of death?
rds	quires n sign	d by	Depression						1	] Yes	2 □ No 3 □ Pro	obably 4 Unknow
360	e law requires that the has been signed by th je 2 should be detache	Completed	Dementia						24a. Wa	s an opsy formed	24b. Were au prior to death?	topsy findings available
a	yslcian: The lis certificate hadirector, page		Gastritis						1 ☐ Yes	2 🖫		2 No
<b>\rightarrow</b>	slcia	o Be	25. Was case referred to medicaf examiner?  1 ☐ Yes 2 ☑ No	Hospitaf: 1 ☐ Inpatien	• 4EB/O		2004	W	Death (Check only		- Co	
on of	Jing Ph J. After th funeral	tion; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of njury	28c. fn W		28d. Describe		6 □Other (Speci njury occurred	ify)
Division of Vital Records,		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, fa (Specify)	ırm, stre				(Street own, Si	t and Number or Ru tate)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of and manner stat	examination an	e, death	occurred at the estigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	e cause e, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier					nse number			B-13-	

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

Bahram Pishdad, M.D. 9801 Georgia Ave., Suite 3-41, Silver Spring, MD 20902
31. Date filed (Month, Day, Year)

2. Registrar's Signature

AUG 2 0 2004



State

Registrar

			1 - For Stete Registrar		of Marylar		artmen rtificate			and M	P	eg. No.	-	281	22
	Physici	an	Decedent's Name (First, Middle, I	Last)							2. Date of Dea Month		Year	3. Time of	Death
	/Medic		HAZEL		BUNN						August	17, 2004	1	2:44	$A^{M}$
	Examin	er	4a. Fecility Name (If not institution, g						Location o			4c. County of	f Death		
			Washington Adven		<del>-</del>				Park			Monte	gome	ry	
н	Funeral			i. Sex 1 □ M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	<ol><li>Date of Birth (Month, Day</li></ol>	; Year)	9. Birth	place (Stete or ntry)	⁻ Foreign
	Director		240-74-4935 Usual Residence of Decedent	X	58	113.					Aug 14	, 1946	N.	Carolin	<u>na</u>
	land M		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							I0d. Inside Cit	v Limits
	Mary 4 • h¢	ō	MD Montg	OMOTO I		'akoma	Dark						1	1 ☐ Yes	2 🗆 No
	the 286	ec	10e. Street and Number	Officery	1	anulia	10f. Zip	Code				Og. Citizen of W	hat Cou		
	With With	Ō	7333 New Hampsh	iro Avon	110				812					,.	
	ns 23	Funeral Director	11. Marital Status		edent Ever in U	J.S. 13. 1	Was Deced			nin? (Spe	cify Yes or No-	U. S.		an Indian,	
(0	riter c	Fun	1 ☐ Never Married 2 ☐ Married	Armed Fo	orces?				n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		, White,		
ğ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve lates:		1□Yes 2	2 XNo	Specify:			Specify:	Bla	ack	
21215-0036	within 72 hours after death with the Maryland one. than "netural", or items 23e or 28e-1 ehow ta Medical Eserii et maal be rediffied at	ted	15. Decedent's	Education		16a. Dece	dent's Usua kind of wor	Occupa	ition	nd condition		16b. Kind of Bus	iness/In	dustry	
21	thin e.	npie	(Specify only highest of Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	DO NOT us	e retired)	)	OF WORKE	ig				
2	ygien Per th	Completed	12th			H	ousew.	ife				Se]	f		
pu	d off	Be	17. Father's Name (First, Middle, La									Maiden Sumame	)		
Maryland	should be filed within and Mental Hygiene. • marked other than " umatic event, tre Me.	To.	Hezekiah B								a Edmon				
lar	2 sh and ie m		19a. Informant's Name/Relationship	, , , , , ,		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural	Route Number	, City or Town, S	tate, Zip	Code)	
	is 1 and 2 of Health a item 27 is other trace		Mack D. Bunn, S	r. – Hus					shire			koma Par			312
0	Pages 1 nent of H int; if ite iry or ot		20a. Method of Disposition 1 □Burial 2 □ Cremation 3	☐Removal from	State	Place of Dispo cemetery, cren	natory or of	her place				20c. Location - C	ity or To	own, State	
altimore,	tant:		* 4 Donation 5 ☐ Other (Spe	city)	Ft	. Linco				8/21,	/04	Brentwo	od,	MD	
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-4 show appringury or other traumatic event, the Medical Estribut must be rediffed at 90ce.		21. Signature of Funeral Service Lic	ensee	1		Name and				rvices				
	D 2 0 0		23a. Part1. Enter the disease, or co	Likely	un							Maryland	20	752	
. 9			shock, or heart failure. List on	ily obe cause on e	each line.						,			Approximate Interval Betw Onset and De	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. A+	herosol	leretic	Coi	rolic	44 1	Arte	ry di	secte		Oriset and Di	Balli
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):			,						
	1	-	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	uana of\:									
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10	(or as a conseq	derice or).									
•	and and in-trar	хап	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							-		
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit														
387	phys s the	Physician/Medical		d											
Вох 6	certif nding ise a	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna	ancy						23d. Date	of dollar		
ğ	death certifica attending ph	ciar	in the past 12 months?		oirth 2 Feta nant at time of d		Ectopic pre					Mont			<b>sa</b> r
P. 0.	that the death cer ed by the attendir detached for use	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno	own										
	res that igned b	by P	Part II. Other significant conditions	s contributing to d	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tot	acco use contrib	ute to th	e cause of de	ath?
<u>s</u>	n sign	g D	Hypentens	re He	int d	wear	e				1 □ Y€	s 2 No 3	☐ Prob	ably 4 Ur	nknown
00	w requir s been s should	ete	7 '								24a. Was a	24b W	are auto	psy findings av	vailable
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>	/sicie	To B	examiner? 1 X Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DO	Othe	P*		(Check only on	nce 6 □Other	(Cassif	-)	
ō	문 등 등		27. Manner of Death	28a. Date	of Injury	28b. Time of		Bc. Injury Work				w injury occurred		7	
0	ath. r: Aft	atio	1 Alatural 5 Pending 2 Accident investigat		th, Day Year)	Injury	М		es 2 □ N	io					
Division of Vital Records,	Attending Ph or death. ector: After th by the funeral	ertification:	3 ☐ Suicide 6 ☐ Could not determine	ad 289. Place	of Injury - At ho	ome, farm, stre	et, factory.	office		28	Bf. Location (St.	reet and Number	or Rura	Route Number	Θ <i>r</i> ,
	s afte	Cert	TIOMICO	Oulida	ng, etc. (Specin	<b>y</b> )					City or Town	, Siale)			
	ospit hour uner		29a. Certifier 1 Certifying I	Physician: To the	best of my kno	wiedge, death	occurred a	it the time	e, date and	place, ar	nd due to the ca	use(s) and mann	er as st	ated.	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	oney	aminer: On the ba	ner stated.	mon and/or inv	7			OCCUFF90	at the time, da	ite and place, an	a due to	tne cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	1 H	1 +1	1 4,0		License		1		d. Date signed (			
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(	A a		30 Name and address of person wh	to completed caus				_							
	1 (4)			0.1		7600 (	[arro]	Ll Av	renue,	, Tak	ioma Pk.	, MD 20	912		
	Sta Registr		AUG 2 0 2004	Bleed	egistrar's Signa	per									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** 9:16 A M AUG 2004 EVELYN SONDRA /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 10,1927 5 Social Security Number 7. Age (In vrs. last birthday) 6 Sex Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 X F Yrs Washington, DC Director 578-38-8205 77 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in and Mental Hygiene. 7 is marked other than "natural", or tlems 23s or 28s-f show traumatic event, the Medical Examinar must be multified at 1 ☐ Yes 2 ☐ No Director MD Prince George Suitland [ ] 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 20746 United States 3904 Regency Parkway Pages 1 end 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Gaboure1 Lillian Montague Joseph 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Gabourel, Sr. 6404 Rolling Ridge Dr. Capitol Heights, Md. 20743 Health itam 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of F important: if Ita eny injury or of QDCe. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 8/18/04 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia permit. 22. Name and Address of Facility Alexander S. Pope Funeral Home 21. Signature of Funeral Service Licensee 00 5538 Marlboro Pike Forestville, Md. 20747 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC NON-SMALL CELL LUNG CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year ō in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed ! 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No 2 X No 1 🗆 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Diractor: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 01011236852 (VA) AU6 NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LT MC USN MATTHEW NEEDLEMAN BETHESDA MD 20889-5600 . Registrar's Signature 31. Date filod (Month, Day, Year) State Joseph AUG 2 0 2004

Registrar

			State of Maryland / Departm  1 - State of Maryland / Departm  1 - Registrar AMEND ITEM #23b PER PHY G835 e91/02		ental Hygiei	2001 2010	L
	Dhuaisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	ith
	Physicia /Medic		DAURA ANN DENNETT				A M
~	Examin	er		City, Town, or Location of Death		4c. County of Death	
	Funanci		5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Ur		B. Date of Birth	MONTGOMERY  9. Birthplace (State or Fo.	reign
Н	Funeral Director		220-34-3850 1 M 2 M 66 Yrs. Mont		(Month, Day, Ye EPT 28	1937 MD	
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Li	mito
	shove	'n		Ŋ		1 ☐ Yes 2 E	_/
	the N	rect	10e. Street and Number 10f	. Zip Code	10g.	Citizen of What Country?	
	3e or	i D	18711 WASCHE ROAD	20842		USA	
	death	Funerai Director	11. Marital Status 12. Was Decedent Eyer in U.S. 13. Was D Armed Forces? 13. Was D If Yes,	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian, Black, White, etc.	
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nd	be filed ital Hygi id other event, I	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name			
yla	2 should be and Menta Is marked reumatic ev	2	EDWARD W. WESTON	GERTRUD			
Maryland	12 sh h and 7 Is m treum			ress (Street and Number or Rural NASCHE RD., D			
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Is marked other then "neturel", or items 23e or 28e-1 show item 27 Is marked other then "neturel", or items 23e or 28e-1 show other treumatic event. It is Medical Examination was the myllified at		20a Method of Disposition 20b. Place of Disposition	(Name of ! Da		Location - City or Town, State	
MO	m O I		1		/04 R	OCKVILLE, MD	
Baltimore,	permit. Page Department Importent: Il eny injury o		21. Signatur of Funeral Service Ucensee 22. Nam	e and Address of Facility		OUT TELL	
8	89 = 28		P.O	ION FUNERAL HO BOX 366, BA	RNESVIL	LE, MD 20838	
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	Pnysician /Medical	4	Immediate Cause (Final disease or condition resulting in death)	Jeuline			
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38760,	ate the	dicai	d. Sefso				
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orc	w requir been si should	eted	Co Petersally Claumoca	LUMOST 4			
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Vital Records,		e Co		26. Place of Death (	1□ Yes 2□		
		0 8	examiner?    Hospital: 1   Legatient 2   ER/Outpatient 3	Othor		6 ☐Other (Specify)	
n of		Ju: T		28c. Injury at 28 Work?	ld. Describe how in	njury occurred	
sio	death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	1 ☐ Yes 2 ☐ No			
Division	of or Attendate death Director: /	Certification:	289. Place of Injury - At home, farm, street, far building, etc. (Specify)	story, office 28	If. Location (Street City or Town, St	and Number or Rural Route Number, ate)	
7	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Attention that the funeral Director or completely filled in by the fune			red at the time, date and place, ar	d due to the cause	o(s) and manner as stated.	
	n 24 h	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation one)				
	To the To the Comp	M	29b. Signature and tive of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)	
•				56141	8	113/04.	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NASREEN KANGO, MD 7610 CARROLL AV	VE, #205, TAK	ים גם אתר	MD 20012	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11, π205, TAK	JMA PARI	K, MD 20912	
	Registi		ALIC 1 5 2004 Pares	sparks			

r reinia		1 - State Registrar AMEND II	<b>EM</b> #23a-c P	aryland / De _l ER PHY G9:			, ,	eg. 20. () () [	28125
170 000	to-	1. Decedent's Name (First, Middle					2. Date of Deat	th	3. Time of Death
ysicia		Karl Otto Born	nann				August	27, 200	Year 3:40 P
Medica amine		4a. Fecility Name (If not institution			4b. City, Town, or	r Location of De		4c. County o	<del></del>
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eral				e (In yrs. last birthda	y) If Under 1 Year	If Under 24 H			9. Birthplace (State or Forei
ctor		212-62-6446	1 📉 M 2 🗆 F	74 Yrs.	Months Days	Hours Mi	n. (Month, Day, Oct. 24	Year)	Germany
		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·				, - , - ,	Colinary
3	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
ll le	cto	Maryland Wash	ington	Willia	msport				1 ☐ Yes 2 💢 N
20	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	hat Country?
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E .	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No-		- American Indian, . White, etc.
8		1 Never Married 2 Marri	ed 1 □Yes 2 📉 I If Yes, Give	No	1 ☐ Yes 2X No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		White
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	Completed	15. Decedent' (Specify only highes		16a. Dec	edent's Usual Occup ve kind of work done o DO NOT use retired	ation during most of w	orking	16b. Kind of Bus	iness/Industry
	du	Elementary/Secondary (0-12)	College (1-4or 5	0+)					
	S	12		Equ	ipment Ope			Constru	
	Be	17. Father's Name (First, Middle, L	.ast)			18. Mother's N	ame (First, Middle, M	Maiden Sumame,	)
	၉	Peter Bormann					abeth Vol		
		19a. Informant's Name/Relationsh		19b. Ma	iling Address (Street	and Number or I	Rural Route Number	City or Town, S.	tate, Zip Code)
		Gerda Buch/Sist	er		Golden Gat	te Road,	Levittow	n, PA	19057
		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Pomoval from State	20b. Place of Dis cemetery, ci	position (Name of rematory or other place	ce)	Date	20c. Location - C	ity or Town, State
		4 □ Donation 5 □ Other (Sp		Smithsbu	irg Cremat	ory 8/	31/2004	Smithsbu	rg, Maryland
9	ı	21. Signature of Funeral Service L	icensee		22. Name and Addres				
OUCE		S. Warle	Sum						wn, Md. 21742
an cal ner	al Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  List of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of):	ASPI	RATION	PNUEMONTA		Interval Between Onset and Death  1wk
١.	.0		d.						
	Medical	IF FEMALE:	d.						
	ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d.  23c. If yes, outcome 1	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	,
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8/21/04

BOYMANN

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 14 2004 6:45P August Aaron Chew /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Kirby Annapolis Anne Arundel Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1₩ 2□ F Director 216-16-4076 Usual Residence of Decede 81 22 1922 Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show othar traumatic event, the Modical Exercit or roughly be rediffied at 1X Yes 2 ☐ No Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 Kirby Lane 21401

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1943-46 filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 212 XIO Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ω. Food Service Sunervisor US Naval Academy 18. Mother's Name (First, Middle, Maiden Sumame) 12th 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ပ Allen Chew Annie B. Travis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Anderson (Daughter) Kirby Jane Anna Sils / 200. Method of Disposition (Name of cemetery, crematory or other place) altimore, 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran * 4 ☐ Donation 5 ☐ Other (Specify) 8/20/04 Crownsville, Md. Cemeter Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

**Sock, or heart failure.** List only one cause on each line.**

**Do not enter the mode of dying, such as cardiac or respiratory arrest.**

**Md.**

**Transfer of the art failure.**

**List only one cause on each line.** proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician vostale CANCER ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Mellitus 2 110 3 Probably 4 □Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ens lon 24a. Was an autopsy performed? has certificate 2 110 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: director, Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No the funeral 27. Manner Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi-30. Name 4.0 6 50 31. Date filed (Month, Day) 32 angistrar's Signature State 4 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 8/19/04, T.M., Kent Co. Certificate of Death Amended #5 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Earl Reese Coleman, Sr. 0874/200<del>1</del> 8:00p. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 118 E. Main Street Sudlersville Queen Anne's If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/05/1933 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours -34-8987 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Exercines must be notified at No Yes 2 No Directo Maryland Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 E. Main Street 21668 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Scrap Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl E. Colman Elizabeth Gladys Jarvis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl R Coleman, II/Son 1640 Millington, Road, Millington, Maryland 21651 Department of Heatt Important: If Item 21 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Sudlersville Cemetery 08/22/2004 Sudlersville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651 reser 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HORTIC MINAL Physician /Medical Due to (or as a Examiner ENON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes Be 25. Was care referred to medical exampler? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To 1 Yes 2 🗆 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar 29b. Signature and title of sertifier

2 Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wayne 30 Robert 2004 0942 M Clary, Sr. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 25, 1958 **Funeral** 1√M 2□F Months Days Hours 46 219-74-1728 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23e or 28e-1 shov any injury or other traumatic event. If a Medical Examinst must be notified at Maryland Frederick Jefferson 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2396 Broadrun Court 21755 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lawn Maintenance Lawn Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse M. Clary, Sr. Myrtle Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Wright Clary/Mother 2396 Broadrun Court, Jefferson, Maryland 21755 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Jefferson Reformed Cemetery Sept. 3, 2004 Jefferson, MD 1 Surial 2 Cremation 3 Removal from State `4 □ Donation 5 □ Other (Specify) permit. ture of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) end-stage **Physician** lever 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate ba executed Due to (or as a consequence of): Box 68760, as IF FEMALE nse ! 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a d be detached for 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 Pro certificate has been si rector, page 2 should 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 □ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michael S. Rudman 117106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Rudman, 300 South Church Street, Middletown, No 21769 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mar	ylariu /	Certificate of			g. No.2 () ()	4 28129		
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7	Examin	er	Homewood Retirement Center			Williams		Washir			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (	(In yrs. last i	birthday) If Under 1 Year Months Deys		8. Date of Birth (Month, Day, March 30	^{Year)} 1905 P	Birthplace (Stete or Foreign Country)		
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Baltimore,	permit. Pages 1 and Depertment of Health inportant: if item 27 eny injury or other to page.		20a. Method of Disposition  1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State  4 ☐ Donetion 5 ☐ Other (Specify)	ceme	e of Disposition (Neme of etery, crematory or other plac r Hill Cemete			Preencasi			
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08-25-04

Katherine R. Carl

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Records, P.O.	igned by the a be detached t	y P	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	underlying	cause give	en in Part I.	23a. Did	tobacco u	se contribut	e to the cause	of death?
rds	n sign	d by							1 🗆	Yes 2	XNo 3□	Probably 4	Unknown
Vital Records, sician: The law requires ti	s been signal	Completed							24e. Was		24b. Were	autopsy findin to completion o	gs available
E E	page 2	mo								ormed?	deat		or cause or
is is	certificete rector, pag	Be C	25. Was case referred to medical				- 5	26. Place of Dea	ath (Check only				
of V	r this certifice ral director, p	To	examiner? 1 ☐ Yes 2 💢 No	ospital: 1 ☐ Inpatient 2 ☐			Othe Othe	ar: 4 🗆 Nursing H	lome 5 Res			Specify)	
D G	fter th		27. Menner of Death 1 XNatural 5 ☐ Pending	28a. Date of injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	(?	28d. Describe	how injur	y occurred		
Division of for Attending Physiatter death.	tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	omo farm e	M		Yes 2 □ No	28f Location	Street an	d Number o	r Rural Route N	lumber
Or Ai	Direc in by	Certification:	4 Homicide determined	building, etc. (Speci	ify)	Heet, lacti	ory, ornice		City or To			, , , , , , , , , , , , , , , , , , , ,	57775-01;
Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.	To the Funeral Director: After th completely lilled in by the funeral	C	29a. Certifier 1X Certifying Phys	lcian: To the best of my kn	owledge, dea	th occurre	ed at the tim	ne, date and place	e, and due to the	cause(s)	and manner	r as stated.	
• Hos	letely	edical	(Check only 2 Medical Examinate)	ier: On the basis of examin-	ation and/or i	nvestigation	on, in my or	oinion, death occu	urred at the time,	date and	place, and	due to the caus	e(s)
To th within	То th	Me	29b. Signature and title of control	111/01/		2	9c. License	number		29d. Dat	e signed (M	lonth, Dey, Yea	r)
, e	>		> YSUAN (Il	VASVIV			V > 0	2196	N	8-	30-6	79	
70	10		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	, Print)	JOHN	Seatt	7ids 2	11. 1	UD		
0	40.		2050 Wildewood	Conton Ca		VIA	MD	2061	7				
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 1	2004	mis	1200							

					artment of Health and I			
			1 - State Registrar	Ce	rtificate of Death	Reg.	N2004	28131
	Physici	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi			nase		August	25, 2004	6:50 AM
	Examir	ner	4a. Facility Name (If not institution, give stree 729 Regent Court	t and number)	4b. City, Town, or Location of Death	•	4c. County of Death	
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Gaithersburg  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgome	
	Funeral Director		430-30-1379  Usual Residence of Decedent		Months Days Hours Min.	July 3,	1922 Ok1	ace (State or Foreig try) ahoma
	yland		10a. State 10b. County	10c. City, Town or Le	ocation		10	d. Inside City Limits
	Maria l	ctor	Maryland Montgomen	y Gaither	sburg			1 Yes 2 No
	ith the	Oire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
	1 23a	rail	729 Regent Court		20878		U.S.A.	
	er de	Funeral Director		Vas Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, e	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Maryes 2 □ No 1948 – 1948 – 1948 – 1952	1 ☐ Yes 2 X No Specify:		Specify: Whi	te
ğ	72 hours after death with the Maryland natural', or items 23a or 28a-1 show Jisal Examiner must be notified at	ted	15. Decedent's Education	n 16a. Dece	dent's Usual Occupation	168	b. Kind of Business/Ind	
215	within 7 ene. than "n	ple	(Specify only highest grade con	College (1-4or 5+)	kind of work done during most of wor DO NOT use retired)			
Maryland 21215-0036	be filed within 72 hours after death with the Marylar hat Hygiene.  ad other than "natural", or Items 23a or 28a-1 show other than "natural", or Items 23a or 28a-1 show event, the Medical Examinat must be notified at	Completed	12th Grade	Med	dical Technologist		American	Red Cross
ב	d oth	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai		
$\frac{8}{5}$	should be ind Mental marked o	10	Frank Alfred Chase			lizabeth E		
<u>a</u>	a a an		19a. Informant's Name/Relationship (Type, Information Relationship (Type, Information Relation Relati		ng Address <i>(Street and Number or R</i> u Regent Court Gaith			
	1 an Heal em 2 thar		20a. Method of Disposition		psition (Name of matory or other place)		c. Location - City or Tov	
ğ	Se to I		1 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	Valifolii State	matory or other place) ncis Xavier 8/28	101		
Baltimore,			21. Signature of Funeral Service Licensee		2. Name and Address of Facility B1		Leonardtown	η MD η P Δ
ñ	permit. Departr Imports any inju		David A. Goff		22955 Hollywood Ro			
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death)	ns hat backed the death. Do not en uye on each line.  Due to (or as a consequence of):	er the mode of dying, such as cardiac  ANT  HUS  L  1	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):  Due to (or as a consequence of):	- SMALL	- CE	24)	
.O. Box 68	at the death certificate to by the attending physical lached for use as the busher	Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
rds, P.	ires tha signed d be de	by	Part II. Other significant conditions contribu	ting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaci	co use contribute to the	cause of death?
of Vital Record	law requ as been 2 shouk	Completed				24a. Was an	24b. Were autop	sy findings available
ř	he h	E				autopsy performed 1 Yes 2	I? _ death?	pletion of cause of
<u> </u>	ician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
>	d S	은	1 ☐ Yes 2 No Hospi	tal: 1 ☐ Inpatient 2 ☐ ER/Outpatier		ome <b>XX</b> Residence	e 6 □Other (Specify)	
Ē		on:	27. Manner of Death  Natural 5 Pending	Ba. Date of Injury 28b. Time o (Month, Day Year) Injury	Work?	28d. Describe how i	njury occurred	
DIVISION	Atten deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At home, farm, ste building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	the Hospital or a hin 24 hours after the Funeral Dire upletely filled in b	Medical (	(Check only 2 Medical Examinar:	n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	ey, Year)
[m	( (In		1 2 M	D	D3537		1 Au	6,
11	2 ~	-	30. Name and address of person who comple	ted cause of death (Item 23a) (Type,	Print) 11125 RO POCKVIU	EMP	E HIELE	04
	Sta Registr	100	31. Oate filed (Monta OG 2° 6 2004	32. Pegistrar's Signature	Lanks	<del></del>		

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hall

Wendell Pierson, M.D.



leka

D53209

3001 Hospital Drive, Cheverly, Maryland 20785

			1 - State of State of Registrar	f Maryland / Dep <i>Ce</i>	artment of Healt <i>rtificate of Dea</i>		Hygiene Reg. No.	nni.	28133
	E		Decedent's Name (First, Middle, Last)				of Death		3. Time of Death
	Physici /Medio		EDWARD E.	COLLICK		Augu	h Day I <b>st 18</b>	Year 2004	12:05 A ^M
	Examir		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Locati			County of Death	12.03 1
			SOUTHERN MARYLAND HOSE		CLINTON	dag Od blan I a -		RINCE GE	
	Funeral Director		215-52-6534 ¹□x ^{M 2□ F}	7. Age ( <i>In yr</i> s. <i>last birthday</i> )  55 Yrs.	If Under 1 Year If Un Months Days Hou	rs Min. 8. Date	th, Day, Year)	Cour	place (State or Foreign htry) INGTON, DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				0d. Inside City Limits
	Maryl f sho	or	DDINGS GROUNDS						1 Yes 2 No
	the 1	rect	MD PRINCE GEORGE S  10e. Street and Number	FORES	TVILLE 10f. Zip Code		10g. Citi	izen of What Cour	ntry?
	h with	ai Di	7218 DONNELL PLACE A-3		20747		U.	S.A.	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any figury or other treumatic event, the Medical Examinar must be notified at ODGe.	by Funerai Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Dece Amed For 1 □ Yes If Yes, Giv Year or Dark	rces? 2≰No e	Was Decedent of Hispanic If Yes, specify Cuban, Mex	tican, Puerto Rican, et	or No-	14. Race - Americ Black, White, Specify:	
9	2 hou atura	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Ki	nd of Business/Inc	dustry
21215-0036	thin 7. e. an "n	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	life.	kind of work done during r DO NOT use retired)	most of working			,
2	ed will ygien her th	Con	2 yı		rdner			ivate	
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)  Edward R. Collick			other's Name (First, M		Sumame)	
7	hould d Mer marke	T _o	19a. Informant's Name/Relationship (Type, Print)	406 14411		nette F. (			
Ma	d 2 sl th an th an 17 ls r treur		Elsie Collick/Wife		ng Address (Street and Nu <b>Donnell Plac</b>				
ē,	Heal Heal tem 2 other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date	-	cation - City or To	
Baltimore,	Pages ent of nt: If i		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	State Harmony	matory or other place)	8/23/2004			
alti	mit. F partm porter / injur		21. Signature of Fune all Service Licen	1	2. Name and Address of Fa			s Funera	
m	Depa Impo any ir		E LA	/	7474 Landove				
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not ent	er the mode of dying, such	as cardiac or respirat	ory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	or as a consequence of):	ARDICALOR	OTH H		1	Onset and Death
	/Medical Examiner		resulting in death)  Due to (death)	or as a consequence of):					
	Lxammer	L		OSCLEROTIC	CARDIZVASC	GLAR DIS	BASE		-
	led nsit	nine	cause. Enter Underlying	or as a consequence of):					
	ficate be executed physicien end s the burial-transit	Examiner	that initiated events	ERTENSIUE C	ARDIEV ASCU	LAR DISE	ASE		
68760,	e be ricier	edicai E	a DiA	BETES ME	LLITUS				
_	± 0.44			75-4-77-77-					
D. Box	thet the death certified by the ettending deteched for use as	Physician/M	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		2	3d. Date of delive Month	ory Day Year
P.O.	het th ad by detecl		Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderhing cause gwen in Pa	230	Did tobacco u	co contribute to th	e cause of death?
Division of Vital Records,	The law requires thet the the has been signed by thoage 2 should be deteched.	ed by	RENAL FAILURE	2011 2011 101 1030 1111 111 111	indenying cadse given in Fa				ably 4 Unknown
ecc	law re as be 2 sho	Completed				24a.	Was an autopsy	24b. Were autop	osy findings available
<u> </u>		Son				101	performed?	death?	
ita /ita	ysician: This certificate director, pag	Be (	25. Was case referred to medical examiner?		26. PI	ace of Death Check of	onl one		
of \	ys dis	L		patient 2 ER/Outpatien		Nursing Home 5			)
n	ding P. After tuner	ion	S Estratoral O Li Orlong	f Injury 28b. Time of Injury Injury	Work?		ribe how injury	occurred	
S	after death after death Director: in by the	licat	3 Suicide 6 Could not be 280 Blace	/A	M 1 Yes 2		ion (Street and	f Number or Rural	I Pauta Number
<u> </u>	2 4 4 2	ertification:	4 Homicide determined 200. Flate buildin	g, etc. (Specify)	eet, ractory, onice	City o	r Town, State)	THURIDON OF MUTAL	noute varriber,
	Hospitel 24 hours a Funerel I stely filled	aC	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, death	occurred at the time, date	and place, and due to	the cause(s)	and manner as sta	ated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the ba	sis of examination and/or in	vestigation, in my opinion, o	death occurred at the t	ime, date and	place, and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c. License numbe	er	29d. Date	signed (Month, L	Day, Year)
		ļ	Victor E. Hern	MD	D2098	(	8-	18-20	104
C	R (4)		30. Name and address of person who completed cause 9/31 PISCATAWAY	of death (Item 23a) (Type,					
	Sta		31. Date filed (Month, Day, Year)	gistrar's Signature					
	Registr	ar	AUG 2 0 2004	W A GOS	West of the second				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12, August 2004 11:08p Ethe1 Craig /Medical 4h City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges 1304 Shady Glen Drive Forestville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 577-32-9798 Days 99 1 □ M 2 1 F Yrs. Director 1904 Elberton, Ga Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ?7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at Maryland PrinceGeorges Yes 2 No Forestville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene in Instruction: if item 27 is marked other than "neturel", or items 23e any injury or other treumatic event, the Medical Event free review 900. 20747 1304 Shady Glen Dr. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: Black þ 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma Sutton Matthew Reuben Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Shady Glenn Dr. Forestville, Md. Ethel Hale / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Aug. 17, 2004 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Alexanderss of Facility Euneral Homes, P.A. 20747 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heimer's **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 1 ☐ Yes 25 (No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21 No Other: ۵ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pendina after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel 29a. Certifier teritying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier  $M, \Sigma$ atucia D0041 30. Name and address of person who completed cause of death (jem 23a) (Type, Print) Patricia G. Wright, M.D., 1900 Massachusetts Ave.S.E. Washington, DC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2 0 2004 Registrar

	1 - For State Registrar	State of Maryland / Depart	artment of Health and Martificate of Death	Mental Hygiene	2001 0010
Physician	1. Decedent's Name (First, Middle, Las		mode of Beam	Reg. No.  2. Date of Death  Month  Day	Year 74 55 AM
/Medica Examine Funeral Director	4a. Facility Name (If not institution, give  Ft. WAS If, reg to re  5. Social Security Number 6. Se	street and number)	4b. City, Town, or Location of Death FT. WASh, ng For, If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	4c. (	County of Death  FG County
Maryland 21215-0036  Maryland 21215-0036  nd 2 should be filed within 72 hours after death vills and Mental Hygiene. 27 is marked other than "natural", or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items 230 or items	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  10e. Street and Number  11. Marital Status  1 Never Married  12 Married  3 Widowed 4 Divorced  15. Decedent's Ed  (Specify only highest grad  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (7	1   Yes   2   No   1   Yes   Give   Year or Dates:    ucation   16a. Decer   Give   I/le.   I/	Nas Decedent of Hispanic Origin? (Sp. 1 Yes, specify Cuban, Mexican, Puerto I Yes, specify Cuban, Mexican, Puerto I Yes 2 Ano Specify:  Jent's Usual Occupation kind of work done during most of work DO NOT use retired)  18. Mother's Name of Address (Street and Number or Rura Address (Street and Number or Rura Address)	ecify Yes or No-Rican, etc.)  16b. King  16b. King  16b. King  17c. Factor  17c. Fa	10d. Inside City Limits 1 □ Yes 2 No en of What Country?  4. A. A.  4. Race - American Indian, Black, White, etc.  5. Specify: 61 4 € / C.  d of Business/Industry
Baltimore, permit. Pages 1a Department of Her Important: If item any injury or othe once.	1 Heurial 2 Cremation 3 5 '4 Donation 5 Other (Specify 21. Signature of Funeral Service License	Mr. Olive	Reported Charles Son	64-04 Littleto	kton N.C. neral Home
S8760, icate be executed physician and physician and strike burial-transit arithe burial-transit and ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	r the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
U ≒ orai u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23	d. Date of delivery Month Day Year
cords, P. ( w requires that the  been signed by  should be detach	Partitioner significant conditions co	ntributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
Vital Record ician: The law requir certificate has been s rector, page 2 should	25. Was case referred to medical		26. Place of Death	autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vital Physician: rithis cartifica ral director, r	1 ☐ Yes 2 ☑ No	Hospital: 2 ER/Outpatient	3 □ DOA Other: 4 □ Nursing Hor	me 5 ☐ Residence 6 [	
E ga ett	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Yeer)  28b. Time of Injury  28b. Place of Injury - At home, farm, stre building, etc. (Specify)	Work? M 1 Yes 2 No	281. Location (Street and f City or Town, State)	Number or Rural Route Number,
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowledge, death ner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurred 29c. License number	ed at the time, date and pl	and manner as stated. ace, and due to the cause(s) signed (Month, Day, Year)
CL (7) State Registrar	31. Date filed (Month, Day, Year)	omplete 1 suse of death (Item 23a) (Type, F	100058797 ngstin Rd. Ft.	Wash. ma	20104. f. 2074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $1^{Day}$ **Physician** Margie A wonth Chase 2004 9:35 am /Medical 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-27-1943 Birthplace (State or Foreign Country)
 N C 6. Sex **Funeral** Months Days Hours Min 1□M ¾□xF 239-60-2809 61 Yrs. NCDirector Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at DC Washington Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 N Street SE #117 20020 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should ba filed within 72 hours after on and Mantal Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Dept. Of Commerce 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Murchison Etta Powe11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is Joyce V. Howard/Guardian 2201 Gaylord Dr. Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or once. Lincoln Cemetery 8-20-04 Suitland, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Funesal Service Licensee 1722 North Capitol St. NW Wash. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dauge on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? ormed) 2 No 2 No 1 Yes 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappier stated. (Check onli To the within 2 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7251 Hanover Pkwy, Suite B, Greenbelt, MD 20770 Patrick A. Noel 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 2 3 2004

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BU.	R COATE	£S	Unpend item# 2	3a 27,28a-f per 3 State of Maryland /	ME, G	835,9/97	04 TT lealth and	Mental Hva	Are Legib iene	ie.
			1 - For State Registrar			tificate of			eg. No?	L 2813
	Physici	an	1. Decedent's Name (First, Middle, Las	it)		<u> </u>		2. Date of Deat Month		3. Time of Dea
	/Media	cal	Wilbur E. Coat			# 65 T		August		004 18:05
	Examin	ner	4a. Facility Name (If not institution, give 1608 Opus Avenue				Location of Deat		4c. County of	e George's
	Funeral		5. Social Security Number 6. S		irthday)	If Under 1 Year	If Under 24 Hrs			Birthplace (State or For Country)
	Director		215-46-2327	© 2 F 60	Yrs.	Months Days	Hours Min.	12 22	1943 M	Iaryland
	pu 🛊 👊		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Liu
	Aanyla I sho	ច	·	_		al Height	S			1K Yes 2
	28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	within 72 hours after death with the Maryland ans. Then "natural", or items 23e or 28e-f show is Madical Examinari, ust be malified at		1608 Opus Avenue			2074	3		U.S.	
	death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of H	ispanic Origin? (S n. Mexican, Puer	pecify Yes or No-	14. Race	- American Indian, White, etc.
98	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		Yes 2⊠ No		o thour, old.,	Specify:	
Ö	hours tural',	Completed by Funeral	3 Widowed 4 Divorced	Year or Dates:	n Doon	lent's Usual Occup	ation			Black
7	in 72 n "nat	olete	15. Decedent's Ec (Specify only highest gra	de completed)	(Give life. L	kind of work done of OO NOT use retired	ation during most of wor f)	rking	16b. Kind of Busi	iness/industry
21215-0036	yiene.	m _o	Elementary/Secondary (0-12)	College (1-4or 5+)		Custodi			Governme	ent
	e filed al Hygie l other vant, II	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		
ylaı	2 should be filed within and Mental Hygiene. Is marked other then aumatic evant, I'le M.	To 5	John Coates				Blanc	he Odento	on	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other then "naturat", or items 23e or 28a-1 show or other traumatic evant, It is Madical Exactinates and be notified at		19a. Informant's Name/Relationship (					ıral Route Number Ltsville,		
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 9009.		Delois M. Coa		-	sition (Name of	venue be.			ity or Town, State
Baltimore,	Pages nent of B int: If ite		1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State cemet	ery, cren	natory or other plac	1			
뜵	permit. Pa Departmen Important: any injury once.		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen</li></ul>			tion Ceme . Name and Addre	4 - 141	/3/2004 C		
Ba	permit. Departr Importe any injt		X X Nava	1000			J	. B. Jenk Handove	cins Funder. Marv	eral Home Land 20785
	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cocaine Intox						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence		TOIL				
	Examiner		Sequentially list conditions,	b						
	pe #si	ine	if any, leading to immediate cause. Enter Undertying Cauc Undertying that initiated events	Due to (or as a consequence	a ot):					
	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	c	e of):					
760,	te be executed ysician and te burial-transit	calE		d						
9	ificate g phy as the									
Вох	The law requires that the death certificat ite has been signed by the attending phyage 2 should be detached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3[	Ectopic pregnancy			23d. Date	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death		Other (specify)			Month	h Day Year
0	at the	Phy	9 Unknown					00- 0:41-1		
	res th	b	Part II. Other significant conditions of	ontributing to death but not resulting	in the ur	iderlying cause giv	en in Part I.			ute to the cause of death  Probably 4 Munkner
orc	requi	eted								
Records,	elaw has b	mpi						24a. Was a autops perform	v prie	ere autopsy findings avail or to completion of cause ath?
			05 11/2					1 Yes 2	P No 1€	Yes 2□ No
Vital	Attending Phyaician: r death. actor: After this certific. by the funeral director,	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Jutantion	t 3 DOA Oth		ith (Check only on		(Specify) SCENE
of	y Phys ar this aral di	7. To	27. Manner of Death	28a. Date of Injury 28b.	. Time of	28c. Injur	/ at		w injury occurred	
lo	death. ctor: After / the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	8/22/04 6	ound :00		Yes 2XNo	Unkn	OWN	
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Sould not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office				or Rural Route Number,
	ital or rs aft ral Di	Cer		found at home					S Avenue Heights	Maryland
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	(Check only 2X Medical Exam	ysician: To the best of my knowledgeninar: On the basis of examination a	ge, death and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the ca	use(s) and mann	ner as stated.
	thin 2 tha tha	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	25	9d. Date signed /	Month, Day, Year)
)	¥ 1 × 0		Marked H	180 Day NO			.C.M.E.			23, 2004
ΔS	a(1)		30. Name and address of person who	completed cause of death (Item 23a	) (Type					
y	<u> </u>		Tasha Zairee	nbera M.D	111	Penn Str	eet, Bal	timore, N	Maryland	21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature						
	Regist	rar	AUG 3 1 2004	sen Is spert	U					

			For 1_ State		aryland / D		nt of H	lealth and M	lental Hygie	ne	. 20130
			Registrar  1. Decedent's Name (First, Middle, Last)			Certificat	le oi L	Jean	Reg.	No. J	3. Time of Death
	Physicia	an							Month		Year
	/Medic	al .	MARY EMMA COLE			4h Cihi	Town	Location of Death	Aug 1	5 20 4c. County of	004   7:38 A ^m
	Examin	er	4e. Fecility Name (If not institution, give s Genesis ElderCa		o Dinos	· · · ·		ston			albot
	<b>-</b>		5 Social Security Number 6 Sex	7. Aq	e (In yrs. last birt		er 1 Year		8. Date of Birth		Birthplace (State or Foreign Country)
- 10	Funeral Director		217-12-4641	M 2₫F		rs. Months	Days	Hours Min.	8. Date of Birth (Month, Day, Y MARCH 8	1926	Country) MARYLAND
			Usual Residence of Decedent								
	nylan how		10a. State 10b. County		10c. City, Town						10d. Inside City Limits
	Ba-f-	cto	MD CAROLIN	E	PR	ESTON					1 ☐ Yes 2 🙀 No
	or 28	Sic	10e. Street and Number			10f. Zi	ip Code		10g	. Citizen of W	hat Country?
	ath w	by Funeral Director	21245 TANYARD RD				216			US	
	er de	nue	Tr. Maria States	12. Was Decedent Armed Forces?		13. Was Dece	edent of Hi ecify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace Black	- Americen Indian, c, White, etc.
36	rs aft	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	NO	1 ☐ Yes	2 <b>X</b> No	Specify:		Specify:	WHITE
윽	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 ehow than "welfeel Exam or mult be notified at	edit	15. Decedent's Edu		16a.	Decedent's Usu	ual Occupa	ation	16	b. Kind of Bur	siness/Industry
15	n n	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	= ()	(Give kind of w life. DO NOT	rork done d use retired	ation during most of worki f)	ng		
212	e filed with al Hygiene. I other than vent, I've M	Completed	8	0	,+,	ASSEM	BLY V	WORKER		ELECT	RONICS
B	be filed tal Hygid d other event.	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle, Ma	iden Sumame	9)
<u>a</u>	should be and Mental marked c	2	REUBIN E. JOINER					ISABELL	E CROSSLE	Y	
Jole Maryland 21215-0036	and and ie m		19a. Informant's Name/Relationship (Ty	•	19b.			and Number or Rura		-	
	and sealth m 27		JERRY T. LEGATES/	SON	DOL Bloom	Commission of Commission (Contraction)		RD RD.,			
Mary (	Pages 1 nent of H int: if ite iry or ott		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R	lemoval from State	cemeter	Disposition (Na y, crematory or	other plac	(8)			City or Town, State
Mary	Pa ant:		*4 □ Donation 5 □ Other (Specify)	11.11	SPRIN			TERY 8-18			MARYLAND
Bal	permit. Departi Import. any inj		21. Signature of Funeral Service License	100		FELLO	WS, I	SS OF FACILITY HELFENBEL	N & NEWNA	M FUNE	RAL HOME PA
	do z a d		23a. Part1. Enter the disease, or compli	MERC		200 S	· HAI	RRISON ST	EASTON,	MD_216	01 Approximate
			shock, or heart failure. List only or	ne cause on each li	ne.	A A	Ado or dynn	1		1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	PY	r, co	lonic	, , 0	x VSC e	51		10W/55.
	Examiner			Due to (or a	a consequence	7	165	,			111. 41
		e	Sequentially list conditions, in any leading to min courts cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of	of:	101	3			9-ENTS
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ć	ie be executed ysician and e buriat-transit		resulting in death) Last	Due to (or as	a consequence	of):					
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68	The law requires that the death certificate in the has been signed by the attending physioage 2 should be detached for use as the base.	Physician/Medi	IS SSWALE								
Вох	th cer tendir r use	an/N	230. Was decedent pregnant	3c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death	3 □Ectopic p	pregnancy	1		23d. Date	of delivery th Day Year
	t the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐Unknown	t time of death	5 Other (s	specify)			IVIOIT	tii Day Toai
P.0	that the ned by I detach	Phy	Part II. Other significant conditions cor	atributifia to doofb b	out oot reculting in	the underlying	001100 0111	on in Part I	23e Did tobar	co use contri	bute to the cause of death?
8,	signe	by	Part II. Other significant conditions con	in La	er not resulting a	i the uncertying	Cause givi	entarranci.	1 Tes		3 ☐ Probably 4 ☐ Unknown
Ö	w requir been si should	ompieted	- all	AUX (V	<i>V</i>				P. P. W.	lau u	
ec ec	e law has t	npi							24a. Was an autopsy performe	d? 245. W	Vere autopsy findings available rior to completion of cause of eath?
표		O							1 Yes 2 ₽	1 No 1	Yes 2 No
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Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At home, fa	rm, street, facto	ory, office				or or Rural Route Number,
ρ	al or /	Certification:	4 Homicide	building, et	ic. (Specify)				City or Town, S	state)	
	Hospitel or 24 hours afte Funeral Dir stely filled in	aic	29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge	, death occurre	d at the tin	ne, date and place,	and due to the caus	se(s) and mar	nner as stated.
		edicai	(Check only 2 Medical Exami	ner: On the basis of	ated.						nd due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	[2) 1)	117	25	9c. Licens	redmun e	29d	. Date signed	(Month Day, Year)
			- Edy	w r	"he		Ud	5 150		8/16	109
				ompleted cause of o	death (Item 23a)	Type, Brint)	1 111	n Augus	11/ 1-0	CTr	MD 21601
	Ex 1		KOBERT SANCHE 31. Date filed (Month, Day, Year)		rar's Signature	LIDHE	LUIN	NETA) [ CI	ULL I	12/00	110 01001
	Sta Registr		Alig 17 1	004	o digitature	1. 1	100				

		WiCHD, dq Amend#23II/08-11-0  1. Decedent's Name (First, Middle, Last			tificate of		2. Dete of Dea	th	3. Time of Death
hysici Medio xamin	cal	Maybelle ( 4a. Fecility Neme (I not institution, give	4			4b. City, Town, or L		4c. County	
neral ector		5. Social Security Number 221-01-3213		rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 1-25-19	W; (O	9. Birthplace (State or Foreign Country) DE.
	J.	Usual Residence of Decedent 10a. State 10b. County	· 10c.	City, Town or Loc			1-25-19		10d. Inside City Limits
the notifi	i Director	Md. Wicomico	)   5	alisbury	10f. Zip Code 21801		1	0g. Citizen of W	<u> </u>
Examiner must be notified at	by Funeral	408 Wicomico St.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:			Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Dican, etc.)		- American Indian, k, White, etc. White
ledical Exp	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give I	ent's Usual Occu kind of work done OO NOT use retire	during most of world	king	16b. Kind of Bus	siness/Industry
event, the N	Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	H	Iomemakeı		e (First, Middle, I	Home Maiden Sumame	
traumatic ev	To B	Charles McCollon				Martha at and Number or Ru	Ferrel1		
any Injury or other		20a. Method of Disposition  1	see S	pringhil 22 Sh 13	Name and Address Ort Fune E. Grov	Gardens ess of Facility eral Home ve St. Del	8-11-04 Inc.	Hebron,	Approximate Interval Between Onset and Death
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use es the buriel-transit	Cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	)	(or as a consequ	· 				
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ge 2 should	Completed	- Chronic ob	structive	pulme	navy	Listan	24a. Was a perform	ned?	available prior to completion of cause of death?
stor, pa	BeCc	25. Was case referred to medical				26. Place of Deal	1 ☐ Ye		1 Yes 2 No
uneral direc	ို	27. Manner of Death	lospital: 1 Inpatient 2  28e. Date of Injury (Month, Day Year)	ER/Outpetient	28c. Inju Wo		ome 5 Reside 28d. Describe ho		
ad in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre		100 2010	28f. Location (St City or Town	reet and Numbe o, State)	r or Rural Route Number,
ly fille	edicai (	29a. Certifier 1 Certifying Phye (Check only one) 2 Medical Exemi	elclen: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation end/or inv	occurred et the til estigation, in my o	me, date end place, opinion, death occur	end due to the ca red at the time, da	ause(s) and men ate and place, ar	ner as stated. nd due to the cause(s)
plete		29b. Signature and title of certifier	/		29c. Licens		)	9d. Date signed	(Month, Day, Year)
complete	×	12 2	Hwy n	0	Do	o 1600 Salist	3	8/8/0	4

			1 - For State Registrar	State of Ivia	-	ertificate of Death	•	Reg. Ne.	4 28140
	Physici	an	1. Decedent's Name (First, Middle, Las				2. Date of De Mønth	_	3. Time of Death
	/Medic Examin	cal	WILLIAM NEIL COLD 497Facility Name (If not institution, give			4b. City, Town, or Location of	of Death	4c. County o	of Death
	LAdiiii	) 	Peninsua Region		Al Center	Salisbury		Wicon	
	Funeral Director		5. Social Security Number 7 6. S 221-28-9103 1  Usual Residence of Decedent	F3 14 0 7 5	(In yrs. last birthda 5 Yrs.	y) If Under 1 Year If Wholer Months Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D 08-23-		9. Birthplace (State or Foreign Country) ELAWARE , PA.
	/land		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
	a-fsh	ctor	DE SUSSEX		DELMAR				11 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of Wh	
	ns 23e	Funerai	101 EAST DELAWARE	12. Was Decedent E	ver in U.S.	19940  3. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	igin? (Specify Yes or N	US. o- 14. Race	A American Indian,
0000	be filed within 72 hours after death with the Maryland ital Hygliene. ad other then "natural", or items 23a or 28a-f show event, the Modical Exertil arranet be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican  1 ☐ Yes 2 ☒ No Specify:			, White, etc. WHITE
ה ק	72 hc natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De (G	cedent's Usual Occupation ve kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Bus	iness/Industry
V	within ene then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	NEVER WORKED		NEVER W	ORKED
2	illed Hygi other ent, I	a	17. Father's Name (First, Middle, Last)				er's Name (First, Middle		
<u>la</u>	should be nd Menta marked matic ev	To B	GEORGE HENRY COLD	REN		ELLE	N HANNAH N	IELDS	
Jan.	2 sho i and ia ma rauma		19a. Informant's Name/Relationship (		1	illing Address (Street and Number			
e G	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		MARK BENNETT - BR	OTHER		D2 SHARKS TOOTH  position (Name of rematory or other place)	DRIVE, MILI		LAWARE 19966 Dity or Town, State
ПОГ	Pages nent of nnt: If it		1 ☐ Burial 2 ☒ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		1	rematory or other place) RY OF DELMARVA	08-12-2004		
Бапптог	artmartminit		21. Signature of Funeral Service Licer		CKEIRIO	22. Name and Address of Facili			
Ď	Depa Impo any i		Theleso	my How	ly	05 EAST MAIN S	TREET, SALIS	SBURY, MAR	
	Pnysician /Medical Examiner		23a. Pairl. Enter the disease, of comprock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due t (or as a	consequence of):	in Syndrom		arrest,	Approximate Interval Between Onset and Death
	uted I Insit	Examiner	Tany Isaan to immediate cause. Enter Underlying Cause (Disease or injury	Due to   41 a3 a	CONSTRUCTION OF				
'n	ifficate be executed ig physician and as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):				
09/80	ate be hysicii the bu	edical		_ d					
O. Box 6	that the death certific led by the attending p detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date Mont	of delivery th Day Year
ds, F	w requires that been signed by should be deta	by	Part II. Other significant conditions of	contributing to death bu	t not resulting in the	e underlying cause given in Part I			bute to the cause of death?  3 Probably 4 Unknown
Hecord		Completed					perf	opsy formed? de	fere autopsy findings available ior to completion of cause of path?
VItal		Be C	25. Was case referred to medical			26. Place	1 ☐ Yes e of Death (Check only		∃Yes 2□No
010	Physician: this certific ral director,	To	examiner?	Hospital: 1 Inpatier			ursing Home 5 Res		
DIVISION	fer ne	Certification:	27. Manner of Death  11 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	Α		y Work? M 1 ☐ Yes 2 ☐	No	how injury occurre	
2	ital or Attendii rs after death. al Director: A led in by the fu	Certifi	4 Homicide determined		ry - At home, farm, . (Specify)	street, factory, office	28f. Location City or To	(Street and Number own, State)	r or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	Medical	29a. Certifier Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best on the basis of and manner sta	examination and/or	eath occurred at the time, date are investigation, in my opinion, dea	nd place, and due to the ath occurred at the time	, date and place, ar	nd due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	han		29c. License number   DO1495		OII.	(Month, Day, Year)
5			30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	D61495 - Salisburg	, 20	2/80/	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	- JUISDUC	y, AW C	11001	
	Regist		AUG 1 1 20	04 Sene	m &	Sporks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

			1 - For Stete Registrer	State of Maryland	/ Depa		lealth and N	Mental Hyg	•	1 20110
П			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th 400	-3. Time of Death,
	Physici		Rosalie L	illian	Doege	9		August		9:30 a. ^M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of	
	LAGIIIII		Chesapeake Woods			Camb	ridge		Doro	chester
ī	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		220–66–4681	^{M 2□ F} 89	Yrs.	Months Days	Hours Min.	June 26	1915	Maryland
	P		Usual Residence of Decedent							
	arylar ahow	_	MD 10b. County Dorchest	10c. City, 1	I own or La					10d. Inside City Limits
)	Ba-f a	cto		er		Cam	bridge			1 ☐ Yes 2 K No
)	or 2	Director	10e. Street and Number			10f. Zip Code	04.64.0	1	0g. Citizen of Wha	
	be filed within 72 hours after death with the Maryland Hygiene. did Hygiene. did othar than "natural", or items 23a or 28a-f ahow evant, the Medical Exertirer must be multiced at		4544 Bucktown Rd.				21613		U.S.A.	
	er de	Funeral		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
30	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:		Specify:	white
2-0036	hour tural			Year or Dates:	160 Door	dent's Usual Occup	ation		10h Kind of Duni	
ÿ	filed within 72 Hygiene. Ithar than "na's ant, Ire Medic	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of work	ring	16b. Kind of Busin	ness/industry
7	withi ene. thar	ЩČ	Elementary/Secondary (0-12)	College (1-4or 5+)		homemake	•		own h	nome
ס ס	filed Hygi othar	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Sumame)	.O.I.I.C
yiand	d be antal cad c	To Be	Houston Malone Tw	illev			Florenc	e Goslir	1	
	should and Men marka umatic	F	19a. Informant's Name/Relationship (Typ		19b. Mailii	ng Address (Street				ate. Zip Code)
ā Z	d 2 h a h a tra		Florence Murphy	daughter		Bucktown			-	
ō,	of Healt itam 2 othar		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place	i nati		20c. Location - Cit	
saitimore,	96 = 2		1 Burial 2 ☐ Cremation 3 ☐ Re  3 4 ☐ Donation 5 ☐ Other (Specify)			er Memoria		/22/04	Comboni d	- MD
	arth orts inju		21. Signature of Funeral Service Licenses		1105 00	. Name and Addres	ss of Facility Th	Omac Fur	Callior Tay	e, MD
ñ	Dep Imp any onc		Bui LB			00 Locust				
			23a. Part1. Enter the disease, or complic	ations that caused the death.						Approximate
١,	Dhamisian		shock, or heart failure. List only one Immediate Cause (Final			· C.	4			Interval Between Onset and Death
Н.	Physician /Medical		disease or condition resulting in death)	Dua to for as a consequent	-/0/	1973	chon			
	Examiner			Due to (or as a consequer  Thirds  Due to (or as a consequer	100011.	- + · ·	heret	· Nico	201	150,000
	•	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):	7077 2	TONT	0150	986	109603
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	huner tel	7.5%	· M				1540xs
ń	be executed ician and burial-transit	Еха	resulting in death) Last	Due to for as a consequer	nce of):	//		·		9000
/60,	ate be executed hysician and he burial-transit	cal	d.							
ĝ	certificate Iding phys									
gox	h cer endir use	Physician/Med	230. Was decedent pregnant	c. If yes, outcome of pregnanc		Ectopic pregnancy			23d. Date of	of delivery
	death e atten	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant at time of deat		Other (specify)			Month	Day Year
j.	at the by th tache	hys	9 🗆 Unknown	9L Unknown						
ທົ	w requires that the death certifica been signed by the attending ph should be detached for use as th	by F	Part II. Other significant conditions cont	ributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
D	aquira en si ould h							1 □ Ye	s 2ੴNo 3[	☐ Probably 4 ☐ Unknown
ecord	law re as be 2 sho	ompleted						24a. Was a	n 24b. Wei	re autopsy findings available ir to completion of cause of
I	0 5 0	Eo						autops perforr 1 \( \text{Yes} \) 2	ned?// dea	th? Yes 2 No
VII	ician: Th certificate rector, pag	Be C	25. Was case referred to medical		×		26. Place of Deat			
> -	Physician: this certific ral director,	^D	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatier	t 3 DOA Othe	er: 4 Nursing Ho	me 5 Reside	ence 6 Other	(Specify)
_	De te		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of	28c. Injun Worl		28d. Describe ho	w injury occurred	
Vision	Attending in death. actor: After by the fune	atle	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Ĕ		ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number on, State)	or Rural Route Number,
ב	spital or ours afte naral Dir filled in	Sel								
	To the Hospitel within 24 hours a To the Funeral C completely filled	edical	(Check only 2   Medical Exemin	cien: To the best of my knowle er: On the basis of examination	edge, deatl n and/or in	occurred at the tin	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To tha Hos within 24 h To the Fur completely	Med	one)	and manner stated.						
	To To CO!	-	29b. Signature and title of certifier			29c. License			9d. Date signed (A	
			Mahrida	<u> </u>			05997	3	8/20/0	4
			30. Name and address of person who con			•				
			Patricia Jo 31. Date filed (Month, Day, Year)	ohnson, D.O.	100	Bramble	St., Caml	oridge, J	MD 2161:	3
	Sta Registr		AUG 2 3 2	2004 32. Restrar's Signatur	B.	pere				

DHMH 17 Rev 1/2001

Registrar

SEP 0 7 2004

			1 - State Amend Item #5	State of M per fh	G835	9/9/0	rtme <i>tific</i> a	nt of H	ealth a Death	and Mo	ental Hy	/giene Reg. No	2001	2811.1	١,
			Decedent's Name (First, Middle, Last)								2. Date of D	eath		3. Time of Death	7
Н	Physicia		Frances Co	rnelius	Do	rsey					Month Augus	t 25	y Year • 2004	10:10 P	М
	/Medic Examin		4a. Facility Name (If not institution, give s.	reet and number	)		4b. Cit	y, Town, or	Location of	of Death		4c.	County of Deeth		
			21353 Bristol Ave	nue				Lexin	gton	Park			St. Mary	¹s	
1	Funeral Director		<b>214</b> 20 8871er 6. Sex 1□	7. A M 2 <b>∑</b> F	ge (In yrs. Ia	st birthdey) Yrs.	If Und Month	er 1 Year s Days	If Under Hours	Min.	8. Date of B (Month, D Sept.	ey, Year)	9. Birth Cou	place (State or Foreigntry) yland	gn
	ט		Usual Residence of Decedent		_						*				=
	how		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limit	
	Pa-f-	cto	MD St. Mary	¹s	L	exingt	on 1	Park						1 □ Yes 2 🔀 N	10
	or 28	Director	10e, Street and Number				10f. 2	Zip Code				10g. Cit	izen of What Cou	ntry?	
	23a		21353 Bristol Ave					206					ited Sta		
	d within 72 hours after death with the Maryland jiene. r then *natural', or Hems 23a or 28a-f ehow the Medical Examinar must be twillfud al	Funeral	Tr. Mariar Otales	<ol><li>Was Deceden Armed Forces</li></ol>	?	3. 13.	Was Dec f Yes, sp	edent of Hi becify Cuba	spanic Ori n, Mexican	gin? (Spec n, Puerto F	cify Yes or N Rican, etc.)	0-	<ol> <li>Race - Ameri Black, White</li> </ol>		
36	or l	by Fi	1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 If Yes, Give			1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: B1	lack	
21215-0036	hour tural		15. Decedent's Educ	Year or Dates:		16a. Deced	dent's I le	eual Occupa	ation			16b K	ind of Business/Ir	duetn	_
5	n 72	lete	(Specify only highest grade	completed)		(Give	kind of v	vork done d	uring mos	t of workin	ng	100.1	110 01 00311633411	loustry	
12	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		mema	-				0	wn Home		
	Hyg Hyg ent,	0	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle				
Maryland	D 0 0	ToB	Albert Dyson Mary Ben								ennett	:			
ar.	s 1 and 2 should by I Health and Mente Item 27 te marked other traumette e	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route								Route Numi	ber, City o	r Town, State, Zi	o Code)	
	t and 2 tealth a om 27 le		Betty A. Goforth	(DAUGH	TER)	2189	5 Pe	gg Rd	. Apt	t. #	225 Le	xing	ton Park	, MD 2065	3
Baltimore,	f Hed		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (A	iame of	σ) [†] Λ,	D:	ate 200/	20c. Lo	ocation - City or T	own, State	
E	Peges nent of int: If It iry or o		20a. Method of Disposition  1XD Burial 2 Cremation 3 Removal from State  14 Donation 5 Other (Specify)  AD Veteran's Cem. Cheltenham  20c. Date Cemetery, crematory or other place)  Aug. 31, 2004  MD Veteran's Cem. Cheltenham									Che	ltenham,	MD	
Ħ	그 돈 만 근		21. Signature of Funeral Service License	1/1/										ome, P.A.	
ä	Depar Depar Impo		David A. Goff	afe of	MO 10									land 20650	)
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on transdate Cause (Final	cause on each	ed the death.	. Do not ent	er the m	ode of dying	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical	İ	disease or condition resulting in death)	Due to for a	2 d	ence of):	we							20740	<u>J</u>
	Examiner			Lich	ment	DALA	100							20ty	Λ
	表态 🔩	je	Sequentially list conditions, if any, leading to immediate	Due to (or a	a consequ	ence of):		^		10				00	<u>J</u> .
	outed nd ransit	Examine	Cause (Disease or injury that initiated events	Dio	Docke	ch	2 gg	XING	met	thy				2413	_
Ó	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or a	consequ	ence of):	m (+	Pin	ص لا	, 1			1	1 14.00	
8760,	ate be nysici he bu	Ca		-rue	XIII	e 10	21	ww	UE					6 //	4
9	artifica ing pl	Physician/Medical	IF FEMALE:		0.7.55.85								1		_
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom ☐Live birth	2 Fetel	death 3		pregnancy					23d. Date of deliv Month	ery Day Year	
0	the a	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknown	at time of de	ath 5∟	Other	(specify)						•	
<u>Ф</u> .	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as		Part II, Other significant conditions con	tributing to death	but not resu	lting in the u	nderlyini	CAUSA CIVE	n in Part I		23e. Did	tobacco i	use contribute to	the cause of death?	
Records,	signe d be	l by	, <del>, , , , , , , , , , , , , , , , , , </del>	<b>,</b>			, , , , , , , , , , , , , , , , , , , ,	,		*		_		bably 4 □Unknow	vn
Ö	v requir been si should I	Completed									242 145		0.45 14/5	E-dis-a-side	- In
3ec	has has	шb										opsy formed?	prior to co	opsy findings availab empletion of cause of	f
alF	10 0										1 Yes	2 No		2□ No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:				Othe	)C		(Check only				
of	Phys this ral di	. To	1 ☐ Yes 2 No  27. Manger of Death	28a. Date of In		ER/Outpatier 28b. Time of		DUA	4 L NU	rsing Hom	8d. Describe		6 ☐Other (Speci	<i>(y)</i>	
n	ding l	fon	1 Alatural 5 ☐ Pending	(Month, D	ay Yeer)	Injury	м	28c. Injury Work	(? Yes 2 ☐				,		
isi	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of I	njury - At hor	me, farm, str	eet, fact	1			28f. Location	(Street ar	nd Number or Rur	al Route Number,	
Division	after Dire Jin b	Certification:	4 Homicide	building,	etc. (Specify,	)					City or To	own, State	)		
	spite		29a. Certifier Certifying Phys	ician: To the bes	t of my knov	vledge, deat	h occurr	ed at the time	ne, date an	id place, a	ind due to the	e cause(s)	and manner as :	stated.	
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in 1	edical	(Check only 2 Medical Examir one)	er: On the basis and manner:	of examinati	ion and/or in	vestigati	on, in my op	oinion, dea	ith occurre	ed at the time	, date and	d place, and due t	o the cause(s)	
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)													
	10		> / We office S	D2/11	^ `	X2		DE	198	2 V	MO	Augu	st 30, 2	2004	
	575		30. Name and address of person who co								i				
_			Michael S. Szkot		A3		lacA	rthur	Blvd	. # 3	54 Cal	lifor	nia, MD	20619	
	Sta	ate	31. Date filed (Month, Day Year)	2004 Regis	rar's Signat	ure n	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR	XXV							

			1 - For State Registrar	State of N	Maryland / D	epartme Certifica			and Me		jiene •g. No⊃ ∏	101.	2811.5
	Physicia	an	1. Decedent's Name (First, Middle,	Last)					2	Date of Dear Month	Dey	Year	3. Time of Death
	/Medic	al	Louis Di  4a. Facility Name (If not institution.	11on, Jr.	e)	4b C	hy Tourn or	r Location o	of Death	August		2004 nty of Deeth	2:52 A M
	Examin	er	Prince Georg			40. 0		ever1				•	George's
- 10 m	Funeral	Ve		6. Sex 7. /	Age (In yrs. last birti		der 1 Year	If Under 2		Date of Birth			oplece (State or Foreign untry)
	Director		435-60-2260	1 X M 2 □ F	66	Yrs. Month	is Days	Hours	Fe	eb. 6,	1938	Lo	uisiana
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location		·					10d. Inside City Limits
	Mary f sho	tor	DC				Wasi	hingto	on				1 ∰Yes 2 ☐ No
	h the	lrec	10e. Street and Number			10f.	Zip Code	HILIEC	011	1	0g. Citizen o	of What Cou	untry?
	23a c	Funeral Director	722 - 24	th St., N.	Ε.			20002	2		Un	ited	States
	er des	nue	11. Marital Status	12. Was Deceder Amed Force	s?	13. Was De If Yes, s	cedent of H pecify Cuba	ispanic Orig n, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		ace - Amer lack, White	ican Indian, , etc.
5	irs aft	by F	1 XNever Married 2 Marrie 3 Widowed 4 Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	<u>a</u> No	1 ☐ Yes	2 X No	Specify:			Spec	city: B	lack
2-003d	72 hou	ted	15. Decedent	s Education	16a.	Decedent's U	sual Occup	ation	of working		18b. Kind of	Business/l	ndustry
7	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	(Give kind of life. DO NO	use retired	during most d)	or working				
7	iled w tygier har th	Cor	11th 17. Father's Name (First, Middle, L	net!		Mec	hanic	- Aut		First, Middle, I		rivat	e
yiana	d be f	o Be		Dillon, Sr				IS. WIOTHE	1 5 14ame (/	Alice		-,	
	shoul nd Me mark	ဥ	19a. Informant's Name/Relationsh			Mailing Addr	ess (Street a	and Numbe	r or Rural A	Route Number			ip Code)
, Mar	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiane. If Heath and Mental Hygiane. If the stransfed other than "natural", or Items 23a or 28a-f show there is narked other than "natural", in Medical Enaminal must be notified at		Dorothy Rorls	- Friend		722 -	24th	St., I	N.E. V	Wash.,	DC 2	0002	
baillmore,	of He		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 □Removal from Stat	20b. Place of cemeters	Disposition (/ y, crematory o	vame of or other place	(8)	Date	9	20c. Location	n - City or 1	own, Stete
	t. Peg tment tant: ijury		`4 Donation 5 Dother (Sp	ecify)	George		_					de1ph	i, MD
סמ	permit. Peges 1 en Department of Heal Important: If Itsm 2 any injury or other once.		21. Signature of Funeral Service L	Xeur						vart Fu N.E. W			20019
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that caus only one cause on each	ed the death. Do n line.	ot enter the m	ode of dyin	g, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)		static Ca								Onset and Death
	Examiner				is a consequence o Lnoma of	-	911S						
	No.	er	Sequentially list conditions, if any, leading to immediate	b	is a consequence o		0-0						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.									
,00,	e exe		resulting in death) Last	Due to (or a	is a consequence o	of):							
0	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	edical		d									
YOU	centifi nding use as	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. D	Date of deliv	/ATV
ŏ	death e atter	Physician/M	in the past 12 months?	4☐Pregnant	2 Fetal death at time of death	3 □Ectopic 5 □ Other						Month .	Day Year
5	at the by the	hys	9 🗆 Unknown	9□ Unknown									
'n	res thi	by	Part II. Other significant condition	ns contributing to death Dysfunction		the underlyin	g cause give	en in Part I.					the cause of death?
corus,	requi	eted	reeding	Dystunction	711				-			3   Pro	bably 4 @Unknown
ב ב	has t	Completed								24a. Was at autops perforn	v	Were autor to condeath?	opsy findings available ompletion of cause of
N I I	in: The	e Co	25. Was case referred to medical					OF Place	of Dooth (	1 ☐ Yes 2		1 Yes	2 □ No
>	ysicia is cert direct	OB	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpa	tient 2 🗷 ER/Out	patient 3	DOA Othe	0.0		5 ☐ Reside		ther /Speci	(fv)
5	ding Physicien: The lav n. After this certificate has funeral director, page 2	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Ti		28c. Injun			I. Describe ho			<i>,</i>
NSIOII	Attanding Pi r death. ector: After th by the funeral	catle	2 Accident investig	ation		М		Yes 2□N	40				
2	or At after d Direct in by	Certification:	4 Homicide determine	ned 288. Place of I	njury - At home, far etc. <i>(Specify)</i>	m, street, fact	ory, office		28f.	City or Town	reet and Nun i, State)	nber or Rur	al Route Number,
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours attent death.  To the Funeral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best examiner: On the basis and manner	of examination and	death occurr Vor investigati	ed at the tim on, in my op	ne, date and pinion, deat	d place, and h occurred	I due to the ca at the time, da	iuse(s) and nate and place	nanner as :	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and Little of certifier			1	29c. License			29	9d. Date sign		
			1 Can	150			04	1295	55		S	3/20	104
1	0 (2)		30. Name and addres arson v						. "01	0 ***		a 000	20
Λ	- 0		Edgar P  31. Date filed (Month, Day, Year)	otter, M.D.	. 1328 S	outher	n Ave	., S.I	t. #21	.u, Was	sn., D0	200	34
	Sta Registr		AUG 2 4 20		J J J	books							
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			1 - For State Registrar	State of M	Marylan		artmen rtificate					giene	2004	281	46
The Age	Physici	an	1. Decedent's Name (First, Middle, L	,							2. Date of Dea	Day	Year	3. Time of I	
1	/Media	cal	SADIE DOWDY				45 03.	<b>-</b>	Location of	- ( D - oth	August	_		4:11	РМ
	Examin	ier	4a. Facility Name (If not institution, gr L & L Perso		<i>(1)</i>		4b. City,		ttsvi			40.	County of Deat	n George <b>'</b>	او
	Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. i	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h (		hplace (State or	
	Director	Н	577-38-6305	1□M 2€F	96	Yrs.	Months	Days	Hours	Min.	Aug. 7,	190	8 Nort	h Carol	lina
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City	u Limita
	fanyla sho	5			100. 01.	y, 10411 01 E		1.						1 X Yes	,
	the N	rect	DC 10e. Street and Number				10f. Zip		ngton	<u> </u>		10g. Citi	zen of What Co	untry?	
	h with	Funeral Director	2717 - 6th	St., N.E					20017				United	States	
	ems 2	ner	11. Marital Status	12. Was Deceder	nt Ever in U. s?	S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		14. Rece - Ame Black, WAit		
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show	by Fu	1 XNever Married 2 Married 3 Widowed 4 Divorced		XNo		1□Yes 2				, , , , , ,		Specify: An		
21215-0036	72 hou	ted	15. Decedent's I	Education		16a. Dece	dent's Usua	I Occupa	ation	t of work	ina	16b. Kir	nd of Business/	Industry	
21	- 4 34	Completed	(Specify only highest g	College (1-40	or 5+)		kind of wor DO NOT us								
	ba filed withir tal Hygiene. d othar than event, me M.		12th 17. Father's Name (First, Middle, Las	<b>A</b>		J;	anito	rial			SOT)	A do Lato a		nment	
anc		Be	George F. Dow						TO. MOLTE	o s Nami	Sarah				
Maryland	2 should be and Manta is marked sumatic ev	္	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	or Run	al Route Numbe			(ip Code)	
	ath a		Lillian Winste	ad - Daug	hter	1000	Šw.				Wash.,				
J.	0 0	1 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Ü	20b. P	lace of Dispo	sition (Nam matory or of	ne of	ŋk		Date		cation - City or	Town, State	
Ë	Pages ment of I ant: If it ury or o		'4 □Donation 5 □ Other (Spec		Mar	-					1/2004		Laurel,		
Baltimore,	parmit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	entee	TI	22					tewart				
_	g ⊡ ⊨ e ol		23a. Par(1. Enter the disease, or con	Menous	الما	Da ant ant					N.E. W		, DC 2	20019	
			shock, or heart failure. List onl	y one cause on each	line.	i. Do not ent	er the mode	e or uying	y, such as	cardiac	or respiratory ar	rest,		Approximate Interval Betw Onset and De	/een
T	Pnysician /Medical		disease or condition resulting in death)		YOC as a consequ	ARDIA	1	FW F	ARC.	丁					
	Examiner			. H		STON	2012	7							
	n =	ner	Sequentially list conditions, 14, leading to innediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consider	uence of):									
	ecutac and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	Typi		DIA	507	5 M	155	LITUS				
8760,	ate be executad hysician and the burial-transit	cal E	rooming in dodiny 2200	Due to (or a	as a consequ	uence or);									
687	physicate sthe			d						-					
Box (	eath certifica attending ph I for use as th	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon								2	3d. Date of deli	very	
œ.	death e atte	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant	at time of de		Ectopic pre Other (spe						Month	Day Ye	ear
P.0	at the de by the stached	hys	9 🗆 Unknown	9□ Unknown											
<u>s</u>	The law requires that the death certificate be executed to has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death	i but not resi	ulting in the u	nderlying ca	ause give	en in Part I.					the cause of dea	
Vital Records,	w requir been si should	Completed									-				
3ec	e law has b	mple									24a. Was a autop perfor	sy	24b. Were aut prior to c death?	topsy findings av ompletion of cau	vailable use of
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	g Physer this eral di	1	27. Manner of Death	28a. Date of Ir (Month, I		28b. Time of		Bc. Injury Work			28d. Describe h			wroup II	lome
<u>0</u>	Attending I r death. actor: After by the funer	atlo	1 🗷 Natural 5 🗌 Pending 2 🗋 Accident investigation	on	Jay ( 6ai)	Injury	М		r ∕es 2 🗆 l	No					
Division	F F F	Certification:	3 Suicide 6 Could not determine	d 28e. Place of	Injury - At ho etc. <i>(Specif</i> y	ome, farm, str	eet, factory	, office			28f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Numbe	er,
	Hospital 4 hours a Funeral C		29a. Certifier 1 📉 Certifying F	Physicien: To the be	et of my know	wledge deati	n occurred :	at the tim	a data an	d place	and due to the o	21160(6)	and manner as	stated	
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medicel Exe	eminer: On the basis and manner	of examinat	tion and/or in	vestigation,	in my op	pinion, deal	th occurr	ed at the time, o	late and	place, and due	to the cause(s)	
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	1			29c.	License	number		2	29d. Date	signed (Month	, Day, Year)	
)					5			17	311			8	1190	4	
CK	(6)		30. Name and address of person who					7 <b>+</b>	N TT	, NT	Тотто	# /. 20	0 111	DC 0	0010
			Francisco ( 31. Date filed (Month, Day, Year)		strar's Signa		ving :	οτ.,	N.W.	, N.	Tower,	# 4 Z U	u, wash	., DC 2	.0010
	Sta Registr		AIIG 2 4 200			has	120								

State of Maryland / Department of Health and Mental Hygiene

		·	cate of Death	Reg. Ng O O 1	
		Decedent's Name (First, Middle, Last)		2. Dete of Death	3. Time of Death
	Physician /Medical	REGINALD LEE DARDEN		August 16, 2 cof	6:30 M
)	Examiner	4a Fecility Name (If not institution, give street and number)	4b. City, Town, or Lo		
		Laurel Regional Hospital	Laure	111100	
	Funeral Director		Inder 1 Year If Under 24 Hrs.  In Days Hours Min.	8. Date of Birth (Month, Day, Year) 1962 9. Bir Co	thplace (State or Foreign ountry) rginia
	Jend #	10a. State 10b. County 10c. City, Town or Location	1		10d. Inside City Limits
	Many art sh	MD Prince George's Laurel			1 XYes 2 □ No
	frer deeth with the Ma r Items 23s or 28s-fs incer must be notified Funeral Director	501 Main Street # 223	f. Zip Code <b>20707</b>	10g. Citizen of What Co	ountry?
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified and note.  To Be Completed by Funeral Director	1 Nover Married 2 Married 1 Nover 2 No	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto es 2 (Str.) Specify:		
5-0	72 h	15. Decedent's Education 16e. Decedent's (Specify only highest grede completed) (Give kind of Give Usual Occupation of work done during most of working OT use retired)	16b. Kind of Business	/Industry	
121	within then the mpi	Elementery/Secondary (0-12) College (1-4or 5+) 1 yr Disabili		Private	2
d 2	Hygie ther ther ont, in	17. Fether's Neme (First, Middle, Lest)		(First, Middle, Maiden Surname)	
an	Mental H Mental H arked ott artic ever	Evangeline Darden		y Wills	
Maryland	shour Maria	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add	dress (Street and Number or Rura	al Route Number, City or Town, State, .	Zip Code)
	alth e	Shirley Wills Darden/Mother 501 Main	n Street # 223 1	Laurel, Maryland 2	20707
Baltimore,	Pages 1 of He nent of He ant: If Item ury or oth	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition cemetery, crematory  Ft. Linco	(Name of or other place)  In Cemetery 8	Date 20c. Location - City or 24/04 Brentwood	
Balt	permit. Depertr Importa any inji			B. Jenkins Funer Landover, Marylan	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. /tunal Tunum  Due to (or as e consequence	deficiency	Virus	Onset and Death
	ii d				I 
	rificate be executed no physicien end est the burial-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	of):	!	
68760,	sicier sicier e buri	that initiated events	ot):		
	certificat rding phy use as th	resulting in death) Last	Vi).		
Вох	leath cer ettendir d for use Iclan/A	Part II. Other significant conditions contributing to death but not resulting in the underly	ing aguse given in Red I	23b. Did tobacco use contribute	to the cause of death?
P.O.	thet the death cer ed by the ettendir deteched for use / Physician/h	Renal Disease	ing cause given in raiti.	1 Yee 2 No 3 P	
Records,	The law requires thet the death certificete be executed sete has been signed by the ettending physicien end page 2 should be deteched for use as the burial-trensit Completed by Physician/Medical Examin			performed?	Were autopsy findings available prior to completion of cause of death?
č	The law stee has pege 2			1 Ves 3LINO	1 ☐ Yes 2 ☐ No
/ita	certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of Vital	his his	↑ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3		me 5 Residence 6 Other (Spe	ocify)
	Ilng P	27. Manner Teath  1 Natural 5 Pending (Month, Dey Year)  1 Natural investigation  M	Work?	28d. Describe how injury occurred	
Division	tai or Attending P rs efter death. al Director: After t led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fa building, etc. (Specify)		28f. Location (Street and Number or Ru City or Town, State)	ural Route Number,
	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (Check only  (			
	ithin 2 or the pomplet	one) end manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)
	Z Z Z S	Abold Alet. Do			
_	10 (1)	30. Neme and address of person who ampleted cause of death (Item 23e) (Type, Print)	1100 53 17	1 / Jugasi	1
(	1- (4)	SALVAdor Sylvester, 3001 Hospita	al Drive, U	7 August 1 heverly Maring	, land
	State Registrar	31. Date filed (Month, Day, Yeăr)  32. Registrar's Signeture	,		

DHMH 16 Rev 6/95

# 115, Junita

		1 - State of M Registrar		artment of Health <i>rtificate of Death</i>	7	Reg. No. 0 0 4	28148
Physicia /Medic		Decedent's Name (First, Middle, Last)     JUANITA		DAVIS	2. Date of Dea Auous	ath 19 2004	3. Time of Death 13:31PM
Examin		4a. Facility Name (If not institution, give street and number Doctor's Community Ho:		4b. City, Town, or Location Lanham	of Death	4c. County of Death Prince George	s
Funeral Director		5. Social Security Number 110-56-6681 6. Sex 1 M 20 F	Age ( <i>In yr</i> s. last birthday, 68 Yrs.	If Under 1 Year	or 24 Hrs. 8. Date of Birt (Month, Da) June 25,	y, Year) Coun	ace (State or Foreign try)
aryland show	_	Usual Residence of Decedent  10a. State	10c. City, Town or L Lanham	ocation		11	Od. Inside City Limits  X□Yes 2□No
with the Marylan 3a or 28a-f show	Funeral Director	10e. Street and Number 6223 BrightLea Dr.		10f. Zip Code 207		10g. Citizen of What Coun	
72 hours after death w 72 hours after tams 23a "natural; or itams 23a	by Funera	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married	Дио	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specify		- 14. Race - Americ Black, White, Specify: Blac	etc.
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  College (1-4c)	(Give	dent's Usual Occupation a kind of work done during mo DO NOT use retired) te Examiner	ost of working	Governmen	,
should be filed within and Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last) David	Banks	18. Moti Sara	her's Name <i>(First, Middl</i> e, ah	Maiden Sumame) Bryant	
; IVICILY and 2 shou ealth and M n 27 is mar ser traumat	-	19a. Informant's Name/Relationship (Type, Print) Herman L. Davis, Husba		ing Address (Street and Number 1997) BrightLea		er, City or Town, State, Zip	,
parmit. Pages 1 and 1 permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr.		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Removal from Sta  4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) n Vet. Cemetery	8/25/04	20c. Location - City or To Cheltenham	
permit. Departm Importa any inju		21. Signature of Funeral Service Lipensee		2. Name and Address of Factionchi F.S. 814 (		ashington, DC 2	0011
Physician /Medical Examiner			n Metasta as a consequence of):	iter the mode of dying, such a	is cardiac or respiratory ar		Approximate Interval Between Onset and Death 2 - 3 mcnths
The law requires that the death certificate be executed are been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	as a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certification 24 hours attended to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
us, r luires that signed b	by	Part II. Other significant conditions contributing to death  Diabetes mellitus	n but not resulting in the (	underlying cause given in Par		obacco use contribute to th Yes 2 No 3 Prob	e cause of death? ably 4 □Unknown
The law requires the has been signs page 2 should be	Completed	Coronaug heart	emia wis	h Injuste	24a. Was autop perfo	prior to cor death?	osy findings available inpletion of cause of
i VICAL  Nysician: T  nis certificat  director, pa	To Be (	25. Was case referred to medical examiner?  1 Xyes 2 \sum No Hospital: 1 \sum Inpa	atient 2X EP/Outpatie	Cthor	ce of Death <i>(Check only o</i> Nursing Home 5 - Resid	one) dence 6 ⊟Other (Specify	)
VISION OF VICE Attending Physician: ar death. actor: After this certifics by the funeral director, I	ertification:	2 Accident investigation	njury 28b. Time o Day Year) Injury	of 28c. Injury at Work?  M 1 Tyes 2		now injury occurred	
tal or Atters after de al Diracte ed in by ti	Certific	3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, farm, s etc. (Specify)	treet, factory, office	28f. Location (S City or Tox	Street and Number or Rura vn, State)	l Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the beside the control of the control of the certifier one)	of examination and/or in	nvestigation, in my opinion, de	eath occurred at the time,	date and place, and due to	the cause(s)
To t To t Com	Σ	29b. Signature and title of certifier	5	i)— į 9 2	50	29d. Date signed (Month, I	Day, Year)
ch t		30. Name and address of person who completed cause of AE S. CHUNG 9470 A.	of death (Item 23a) (Type	1, Print) 28 SUITE 306	o LANTAN,	MD 20708	0
Sta			strar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year) AUG 20 2004

asna

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)



111 Penn Street, Baltimore, Maryland 21201

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	Physici	an	Decedent's Name (First, M			_						2. Date of De Month	Di	ay Year		of Death
	/Media	cal	Michelle Lei  4a. Facility Name (If not institu					4b. City.	Town, or	Location of	of Death	Augus		7 , 2004 c. County of De		27 A M
	Examir	ier •	Shady Grove				al		kvil		, Boati,			1ontgom€		
77	Funeral		5. Social Security Number	6. Se	K		yrs. last birthday	-		If Under	24 Hrs. Min.	8. Date of Bi (Month, D	irth		irthplace (State Country)	e or Foreign
2	Director		218-86-4264 Usual Residence of Decedent		]M 2[X]F	28	Yrs.		,-			April	18,	1976 Ma	ryland	
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36	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or itams 23a or 28a-f ahow ant, it e Madical Examination notified at	by Funeral	11. Marital Status  1 X Never Married 2 □ N 3 □ Widowed 4 □ Divor	Married	Armed F	Forces? 2 🔀 No Sive	in U.S. 13.	If Yes, spec			gin? (Spe i, Puerto Unkno	ecify Yes or Ne Rican, etc.) OWN	0-	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
9	2 hou	ted t	15. Dece	dent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ation			16b. i	Kind of Busines	s/Industry	
Baltimore, Maryland 21215-0036	I within 73 liene. r than "n	Completed	(Specify only high			(1-4or 5+)	life.	kind of wor DO NOT us Zer Wo	se retired	) -	t of worki	ng		/ A		
פֿב	e filed al Hyg other	Bec	17. Father's Name (First, Mide	fle, Last)			, NC	CI WC	)I KEL		r's Name	(First, Middle				
arylaı	2 should be filed within and Mental Hyglene. Is markad other than aumatic avant, Ite M.	Tof	Santago Me 19a. Informant's Name/Relati	rete	rpe, Print)		19b. Mail	ng Address	(Street a			irginia N Route Numb		ore or Town, State,	Zîp Code)	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or itams 23a or 28a-f ahow amy injury or other traumatic event, It e Modical Examiner must be notified at once.		Jose Merete /	Brot	her		19 N	Loci	ıst S	St Ap	t. 2	Hagers	stow	n MD 21	740	
ore			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremati	on 3.∏E	lemoval from		b. Place of Disp cemetery, cre	sition (Nan	ne of			ate		ocation - City o		
Ë			1 Burial 2 M Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Smithsburg Crematory Aug 31 2004 Smithsburg Maryland  21. Signature of Funeral Service Licensee													
Bai			21. Signature of Funeral Service Licensee  22. Name and Address of Facility Rest Haven Funeral Chapel  1601 Pennsylvania Ave Hagerstown Maryland 21742													
			23a. Part 1. Enter the disease	or compl	ications that	caused the								own Mar	yland 2	
	Physician /Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	ist only or	e cause on Coca	aine I	ntoxica			9, 00017 00					Interval B Onset an	Between
	Examiner	e	Sequentially list conditions, if any, leading to immediate		Due to	o (or as a con	sequence of):									
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o	Phys arthis araldi	: To	1X Yes 2 No 27. Manner of Death	1	28a. Date	of Injury	2 X ER/Outpatie 28b. Time o		8c. Injury	at		ne 5 ☐ Resi 28d. Describe		6 □Other (Spe	ecify)	
- No	noing ata: r: Afte e fune	allor	1 Natural 5 Per 2 Accident inv	nding estigation	8/27 foun	7024 ^{9 Yea}	2:50 ^y found	- M	Work	:? ∕es 2.5 <b>x</b> †		unkno		,		
Divis	To the Hospital or Attanding Physician: The lawithin 24 burus after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6X Co 4 ☐ Homicide	uld not be ermined	28e. Plac	e of Injury - / ding, etc. (Sp	At home farm et		, office		2	28f. Location ( City or To	Street al	nd 452°G1 Co., M	rard S	^{mber} ,#30 d
	e Hospita 24 hours a Funara letely fille	edical (	29a. Certifier 1 Certi (Check only one) 1 Medi	fying Physical Exami	ner: On the I	ne best of my basis of exam nner stated.	knowledge, deal mination and/or in	h occurred vestigation,	at the tim in my op	ie, date and pinion, deat	d place, a	and due to the	cause(s	and manner a	s stated.	
	To th within To thi	Me	29b. Signature and title of cer	ifier				29c	. License	number			29d. Da	ate signed (Mon	th, Day, Year)	
			Jaska	314	wen	berg	Ma	0	.C.M	ι.Ε.			Aug	gust 27,	2004	
H			Jaska 30. Name and address of personal Taska Z	(SV00	nhora	3 M.D	111	Penn	Str	eet,	Balt	imore,	Mar	yland 2	1201	
	Sta Registi	7	Tasha Z Giveen berg M.D., 111 Penn Street, Baltimore, Maryland 21201  31. Date filed (Month AUG Yeg) 1 2004  32. Prisistrar's Signature  B. Speck													

Amend item/19a,perInf (391.3/3/05 TT)
State of Maryland / Department of Health and Mental Hygiene For 8-20-04 Registrar Amend 26. Per Phys. PGC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Armando Ernesto Espinoza Lazo 10 M 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month, Day, Year) 1944 9. Birthplace (State or Foreign (Month) 1944 9. Birthplace (State or Foreign (Month) 1944 9. Birthplace (State or Foreign (Month) 1944 9. Birthplace (State or Foreign (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (State or Foreign (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Birthplace (Month) 1944 9. Bi 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Director 218-67-3530 60 Yrs. January 20, El Salvador Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Itams 23e or 28e-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EL 9615 Horizon Run Road 20886 San Salvador; Salvador Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Hispano Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Commerce Consultant Self Employed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be filment of Health and Mental Hent: If Item 27 Is marked oth jury or other traumatic even Ernesto Espinoza Maria Lazo 19a. Informant's Name/Relationship (Type, Print) (Wife)
Lucrecia Sanchez Paredez Espirozafe) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 9615 Horizon Run Road; Gaithersburg, Maryland Lucresia Sanches Pareres Espinosa Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)  $July\ 31$  , 2004 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State permit, Page Department of Importent: If any njury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Santa Cruz Servicios Funerarios arranian 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician VENTRICHEAR FIBRILLATION disease or condition resulting in death) MAICOIDE /Medical Due to (or as a consequence of): Examiner MASSIVE MYOCARIOIDE LAFAETION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Due to (or as a consequence of) Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9☐ Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUI 24b. Were autopsy findings available prior to completion of cause of death? HYPER TENSION 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 # P/Outpatient 3 ☐ DOA Other: 4 Nursing Hom 5 dec 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the f after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10054135 27, N.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL DRIVE GAIDMINSSURE MIN Duc it, Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 2:29 Drooke Edick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore niversity Maryland Hospital laryland Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Hours Director 1981 Maryland 212-17-3641 23 19, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 21808 Magnolia Drive 20619 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ▼No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other then any injury or other treumatic avant. Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Unemployed</u> None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brad David Edick Robbin R. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brad David Edick / Father 21808 Magnolia Drive, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield - Echols * 4 ☐ Donation 5 ☐ Other (Specify) 08/24/2004 Charlotte Hall, MD 21. Signatur of Funeral 5 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01095 22955 Hollywood Road, Leonardtown, MD 20650 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, albey on each line. Part . Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final erebral **Physician** Edema Days disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Hate myelogenous

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and ched for use as the burial-transit The law requires that the death certificate ba executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🖺 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide t 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SAO 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 22 Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Marylan				•	•	
		1 - State Registrar		Cei	rtificate of	Death		Reg. No. 0 0	28/53
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day Year	3. Time of Death
/Medi			nbrey		T		Augus	1	9:30 p M
Exami	ner	4a. Fecility Name (If not institution, give stre 10414 Tullymore Dra			4b. City, Town, or Adelphi	r Location of Dea	in	4c. County of Dea Prince Ge	_
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Director		219-12-2666 ¹™™	^{2□ F} 79	Yrs.	Months Days	Hours Min	8. Date of Birt (Month, Da Jan. 22	, 1925 Mar	yland
pur *		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	ocation				10d. Inside City Limits
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2 hour		15. Decedent's Educat	ion	16a. Dece	dent's Usual Occup	ation	· · ·	16b. Kind of Business	/Industry
Fin 7:	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo d)	orking		
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tem tem tem		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place	1	Date	20c. Location - City or	
Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	noval from State				st 26,04	Cheltenham	, Maryland
Darkimore, permit. Pages 1 an Department of Heal Important: If tem 2 any injury or other once.		21. Signature of Funeral Service Licensee	1 1 ,	22				uneral Home	
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p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseq	mence of):					
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death certifical eathending physical set to use as the	Physician/Medi	23b. was decedent pregnant	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		∃Ectopic pregnancy	,		23d. Date of de	
he death	Sicis	in the past 12 months?  1  Yes 2 No	4☐Pregnant at time of o		Other (specify)			Month	Day Year
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d be d	d by	Takin only against the same some	outing to doubt but not room	and grant and a	indonying dadoo gri	J		Yes 2□No 3□P	
ecords law requires as been sign 2 should be	Completed						24a. Was	an 24b. Were a	utopsy findings available
The lar	a mo			· · · · · · · · · · · · · · · · · · ·				prior to death?	completion of cause of
VICAL iclen: 1 certificat ector, p	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o		2010
OT V Phyaic Phyaic rthis ce	10	To res 2000	pital: 1 Inpatient 2 I			4   Indising		dence 6 Other (Spe	cify)
on c	ion	Taratulal Ollifolialing	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occurred	
MISION r Attending er death. rector: After	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str		183 2 100	28f. Location (5	Street and Number or R	ural Route Number,
al or /	Certification:	4  Homicide	building, etc. (Special	(y)	,,		City or Tow	wn, State)	
To the Hospital or Attending Physicien: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.		29a. Certifier 1 X Certifying Physic.	ian: To the best of my kno	wledge, deat	h occurred at the tin	ne, date and plac	e, and due to the	cause(s) and manner as	s stated.
the H hin 24 the F	Medicai	one)	and manner stated.						
To Tool	~	29b. Signature and title of certifier	<i>(.</i> /		29c. Licens			29d. Date signed (Mont	
- P-1		30. Name and address of person who comp	pleted cause of death (Iter	n 23a) (Tune	D0983	) <del> </del>		August 23,	2004
CRIGI	19	Barry N. Rosenbaum			gut Avenu	ie, Kens:	ington, N	D 20895	
	ate	31. Date filed (Month, Day, Year)	→ Registrar's Signa	ature_	٠. قد				
Regist	rar	AUG 2 4 2004	Elder &	Local					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:38 AM 0.8 MARTON **ESHAM** 13 /Medical 4b. City, Town, or Location of Death 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 □ M 2 🕅 F 70 221-20-5426 Yrs 1933 WILLIAMSVILLE, DE 24, Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND WICOMICO SALISBURY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 913 COLONY DRIVE 21804 USA itema 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) TRANSCRIPTIONIST COURT REPORTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. Be RENDAL Κ. MILLER FLORENCE ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW H. ESHAM/HUSBAND 913 COLONY DRIVE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) BISHOPVILLE CEM. 8/16/04 BISHOPVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 Tus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HIPOXEMIA Physician /Medical Due to (or as a consequence of) **Examiner** STAGIE NI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusto or as a con suence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an THYROID ISM autopsy performed AILUME 1 Yes 2 No ONGESTIVE 1 Yes 2⊠ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 A ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide filled within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 206051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY MD 21804 31. Date filed (Month, Day, Year) AUG 17 2004 32. Registrar's Signature State

Registrar

Box 68760.

P.O.

Division of Vital Records.

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	٠.		30. Name and address of person who completed ca	use of death (Item 23a) (Type,		li Tina	7 m M			
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Donald Foster

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Maryland	12 sh and ls m		19a. Informant's Name/Relationship (T)	•			and Number or Rura				ode)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itams 23a or 28e-1 show any injury or other traumatic event, the Modeal Examination and be published at once.		21. Signature of Funeral Service Licens						IURLOCK	•	
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Вох	eath certificate attending phy I for use as the	cian	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	ol delivery th Da	ay Year
P.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	by Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	110 01 dozum 5 _				ļ		
	res that igned b be deta	y Pł	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contri	bute to the	cause of death?
ıd	w require been sig should b							1 ☐ Yes	2 🖰 No	3 ☐ Probab	ly 4 □Unknown
ecc	e law re has be je 2 sho	piet						24a. Was an autopsy	24b. W	/ere autopsy	y findings available letion of cause of
<u>~</u>	The cate h	Completed						perform	ed? de	eath? □Yes 2[	
Vital Records,	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		t 3□ DOA Othe	26. Place of Death				
	Phys r this oral di	: To	1 ☐ Yes 2 ☑ No  27. Man or of Death	28a. Date of Injury (Month, Day)		I SLI DOA	4   Nutsing Hon	ne 5 🗌 Resider 18d. Describe hov			
on	nding tth. :: Afte e fune	atior	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	Year) Injury	Work	(? Yes 2 □ No		,,		
Division of	er dearector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str	eet, factory, office	2	281. Location (Stre City or Town,		r or Rural F	loute Number,
ō	itel ou rrs aft rel Dii led in			J	(-,,			0.1, 0			
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier 2 Certifying Phy (Check only one)	sician: To the best of iner: On the basis of e	xamination and/or in-	occurred at the time vestigation, in my op	ie, date and place, a pinion, death occurre	and due to the cau ed at the time, dai	use(s) and mar te and place, a	nner as state nd due to th	ed. e cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner state	3G.	29c. License	number	29	d. Date signed	(Month, Da	y, Year)
	F 3 F 8		· Muzi of	ruent		13	1887		8/14/	04	
			30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type,	Print)			-1.(1	J	
			DAVID SMITH				MD 21601				
	Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar	s Signature	1					
DH	IMH 17 Rev 1/2	-	AUG -	WVVT JUNE	m St.	forth					

			For State	State of Maryland					2001	001777
			Registrar  1. Decedent's Name (First, Middle, Last)	1	Cen	tificate of L	Death	Reg 2. Date of Death	No. U	7.815/
	Physici	an	Emily Kna		h 0 20			Month	Day Yes	
	/Medic		4a. Facility Name (If not institution, give s			4h City Town or	Location of Death	August	9,2004 4c. County of D	
	Examin	er	Snow Hill Nursi		i		ow Hill		Worce	
	Funeral	-	Social Security Number     6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplece (State or Foreign Country)
	Director		187-28-2113 ¹	^{]M 2} 80 F 100	Yrs.	Months Days	Hours Min.	(Month, Day, Y 05/09/		country) 'ennsylvania
	D		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	ation				10d. Inside City Limits
	Aaryle f sho	0 1								1 ⊠Yes 2 □ No
	1he N	Directo	Maryland Worce 10e. Street and Number	ster Si	now H	1 L L 10f. Zip Code		100	. Citizen of What	
	a with		430 W. Market	St.		218	63	1.03	US	•
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28e-f show aumatic event, the Madical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. W		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Rece - A	merican Indian,
9	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give			in, Mexican, Puerto  Specify:	Hican, etc.)	Black, W	
2	ours real.	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:			эреспу.		Specify:	white
7	"nati	Completed	15. Decedent's Edui (Specify only highest grade	cation e completed)	(Give k	ent's Usual Occupa	during most of work	ing 16	b. Kind of Busine	ss/Industry
2	withir ane. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired	"			
2	be filed within 72 ttal Hygiene. d other than "natevent, the Medic		17. Father's Name (First, Middle, Last)	<u> </u>	пот	usewife	18. Mother's Nam	e (First, Middle, Ma	Domes	tic
ä	id be entai ked o	To Be	Elmer Ellsworth	Knabb				lia A. S	•	
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic	Η.	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street a		al Route Number, C		e, Zip Code)
			John F. Fisher	/son	214 I	S. Palm	er Ave	Collin	newood	N.T 08108
ē,	ss 1 and of Healt item 2 rother 1		20a. Method of Disposition	20b. Pla	ice of Dispos	ition (Name of atory or other place	e)	Date 20	c. Location - City	, NJ 08108 or Town, State
E	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)					/12/04	Sal	isbury, MD
Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or otl once.		Signature of Funeral Service License	90	H _C	Name and Addres	s of Facility	l Home E	rofoss	ional Assoc
n	89558		David A. Glom	VODOR CESP	50	1 Snow	Hill Ro	d., Sali	sbury.	MD 21804
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	dations that caused the death.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Der	new	tea				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
	LXG/////C	-	Sequentially list conditions,	Due to (or as a conseque	ance of h					
Т	pet usit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (Di as a conseque	ince or).					
	al-tran	xan	that initiated events cresulting in death) Last	Due to (or as a conseque	ance of):					
9/9	cate be executed physician and the burial-transit	dicai E		4						
9	ificati g phy as the	edic								
ХOЯ	death certific e attending p id for use as	Physician/Me	200. Was decedent program	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy			23d. Date of	delivery
	deat	sicia	in the past 12 months? 1 Pes 2 No	4 Pregnant at time of dea		Other (specify)			Month	Day Year
J O	at the de I by the a etached	Phy	9 Unknown							
Ś	requires that the neen signed by th hould be detache	by	Part II. Other significant conditions con	itributing to death but not result	ting in the und	derlying cause give	en in Part I.			to the cause of death?
ecords,	w require been sig should b	ted	Horance	Hye				1 Yes	2 2 3 □	Probably 4 Unknown
ခို	42 CA	Completed		<u> </u>				24a. Was an autopsy	prior 1	autopsy findings available o completion of cause of
ᇙ	i <b>cian</b> : The certificate harector, page							performed		es 2 No
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	V = -00	Othe		(Check only one)		
ō	Phys r this ral di	- To	1 Yes 2 No	I   Inpatient 2   Ei	R/Outpatient 28b. Time of	3 DOA 28c. Injury	4 pa Nursing Ho	me 5 Residenc 28d. Describe how		pecity)
O	al or Attending P s after death. Il Director: After i d in by the funera	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	(?` Yes 2 □ No	Lod. Describe now	injury occurred	
DIVISION	Atten r deal octor	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, strei			281. Location (Stree	at and Number or	Rural Route Number,
É		Certification:	4 Homicide	building, etc. (Specify)				City or Town, S	State)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier  (Check only 2 Medical Exemit	sician: To the best of my knowl	ledge, death	occurred at the tim	e, date and place,	and due to the caus	e(s) and manner	as stated.
	the H iin 24 the Fi	edical	one)	ner: On the basis of examination and manner stated	on and/or inve	estigation, in my op	oinion, death occurr	ed at the time, date	and place, and c	lue to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	Deret		29c. License			Date signed (Mo	
			P				7442		8-9-	04
			30. Name and address of person who go	mpleted cause of death (Item 2	23a) (Type, P	MI SARA	BARA	MA	2185	-1
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	8 01700			~/05	/
9	Registr		AUG 1 2 20	ampleted cause of death (Item 2)  32. Registrar's Signatur	G	Soone	í V			
			T 12 FO			//				

			For State	State of Maryla	•			Mental Hy	giene	
			Registrar		Cei	tificate of I	Deam		Reg. No.	28158
	Physici	an	1. Decedent's Name (First, Middle, Last	/ / -	v) n/			2. Date of Dea	Day Year	3. Time of Death
	/Medic		4a. Fagility Name (If not institution, give		DIC	4h City Town or	Location of Deat	h	4c. County of De	10.00 F
	Examin	er	Checled Diver	Hospitali	renter	chost	e Zto(2)	(	Kent	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In )	rs. last birthday)	If Under 1 Year	If Under 24 Hrs		h 9. B	rthplace (State or Foreign
	Director		180-14-9769 ¹ x	^{2M 2□F} 82	Yrs.	Months Days	Hours Min.	April A	4, 1922 Per	nnsylvania
			Usual Residence of Decedent							
	show		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	Ba-f.s	ct Ct	MD Kent		Worton	1				
	or 2	2	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	ours after death with the Marylan rat', or Items 23a or 28a-1 show Examiliner must be mottfled at	Funeral Director	24058 Mac's Lane	10 1/1- 5	-11.0	21678		S	USA - 14. Race - Arr	-ciesa Indias
	items	nue	11. Marital Status	12. Was Decedent Ever i	n U.S.   13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	to Rican, etc.)	Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	17 Yes 2 ☐ No If Yes, Give Year or Dates: WW	гт	1 □ Yes 2√□ No	Specify:		Specify:	nite
P	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show coloal Examinant han neithed at	ed	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	
75	n u	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most of wo d)	rking		
212	filed within I Hygiene. other than	E O	Elementary/Secondary (0*12)	2	Ele	ctrical H	Engineer		Telecommun	nications
p	be filed within 72 ho ital Hygiene. od other than "natur event, it e Medical	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u> a</u>	Ments Ments arked	2	William Leroy Gro	om			Charlott	te Elsbet	th Crebs	
Maryland 21215-0036	2 should be financial Mental M	1 19	19a. Informant's Name/Relationship (T)	rpe, Print)	1				er, City or Town, State,	Zip Code)
	and ealth na 27		Helen P. Groom/wi			8 Mac's I	17727 - 1	ALCOHOL STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF T		1678
ore	0 0 = =		20a. Method of Disposition  1 Burial 2 Cremation 3 DF	temoval from State		sition (Name of natory or other place	l l	Date	20c. Location - City of	
Ë			* 4 ☐ Donation 5 ☐ Other (Specify)			ke Cremat		/13/04	Stevensvi.	lle, MD
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licens		, . )	P. Name and Addres Fellows I	lelfenbe:	in & Newn	nam Funera:	l Home, P.A.
	TOTEG	1	23a. Part1. Enter the disease, or comp	egen!					own, Maryla	and 21620 Approximate
			shock, or heart failure. List only o	ne cause on each line.	au o	er trie mode or dym	, such as cardia	c of respiratory at	1631,	Interval Between Onset and Death
	Physician /Medical	8	Immediate Cause (Final disease or condition resulting in death)	a Severe b	eetobole	i Ocido	14			
	Examiner			Due to (or as a con	sequ <i>e</i> nce of):	C10				
		er	Sequentially list conditions,	b. Due or as a con	sequence of):	3 1000				
72	nsit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-57						
,	exect n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
8760,	cate be executed physician and the burial-transit	dical	· ·	d						
		led								
Вох	leath certific attending p	N/NE	230. was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	r		23d. Date of de	,
Э.	ed fo	sicla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
P.0	that the de led by the a detached (	Physician/Me	9 Unknown				- in Boat	ana Dida		10 the course of death?
Ś	88 25 60	ρ	Part II. Other significent conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	230. Did to	obacco use contribute	Probably 4 Unknown
orc	w require been si should I	ted	fea	to vome	Jacken	4			163 22110 0[]	TODADIY 4 CONKIONII
Records,	e law has b	Completed	Lete	istati 1	unto	y con	cer	24a. Was autop	osy prior to	autopsy findings available completion of cause of
E		S	V					1 ☐ Yes		s 2 No
Vital	ding Physicien: 1  After this certifical funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	on	ath (Check only o		
of	Phys this al dir	To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time of	IL 3LI DON	4   Nuising r		dence 6 Other (Sp	ecify)
u	ding f	lon	1 Natural 5 □ Pending	(Month, Day Yea	r) Injury	Wor	k? Yes 2 □ No	200. 2000.100 1	iow injury occurred	
Division	death death ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Injury - /	At home, farm, str				Street and Number or F	Rural Route Number,
ō.	after Dire	Certification	4  Homicide	building, etc. (Sp	ecify)			City or Tou	vn, State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Phy	sicien: To the best of my	knowledge, deat	n occurred at the tin	ne, date and place	e, and due to the	cause(s) and manner a	as stated.
	ne Ho ne Fu	Medical	(Check only 2 Medical Exam	iner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death occi	urred at the time,	date and place, and du	ie to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	001	40	29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
			1 / lu lu	1 45		100	<i>96030</i>	1	5/10/0	Y
				ompleted cause of death	Item 234) (Type,	Print) Or	EALL	2013	C MAN D	1670
			MICHAER HIME			PD STE	3 UTO	JOVIO	wi hand	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 10				

State of Maryland / Department of Health and Mental Hygiene

					y	Certif	ficate of	Death	mornar rry	Reg. No.	200	. 20150
	Physicia	an	1. Decedent's Name (First, Middle, La					~	2. Dete of De Month		<del>- 4 0 '</del>	3. Time of Death
	Physici · /Medic		Odessa Virginia						August	22,	2004	12:15 a.m.
	Examin	er	4a Fecifity Name (If not institution, give					4b. City, Town, or			County of De	
			C. J. Senior Car  5. Social Security Number 6.5		e (in yrs. ias	st hirthday) If	Under 1 Year	Hager			Washi	
	Funeral Director			DM offer	9	Yrs.	onths Days		June 2	y, Year)	905 1	Birthpface (State or Foreign Country) V. Va.
	land		10a. Stete 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits
	Mary	to	Maryland Washi	ngton		Hagers	stown					1⊠Yes 2□No
	or 284	Director	10e. Street end Number			1	10f. Zip Code			10g. Citiz	en of What	Country?
	23a	ral	954 Guilford Ave	nue			2	L740		US	A	
21215-0020	d 2 should be filed within 72 hours aftar daath with tha Maryland th and Mantal Hygiana. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Maritaf Stetus  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Decedent of es, specify Cul Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ai Black, W Specify:	nerican Indian, hite, etc. white
2-0	72 h	Completed	15. Decedent's E (Specify only highest gre			16a. Decedent	's Usual Occu	pation during most of wor	king	16b. Kir	d of Busines	ss/Industry
121	within lana. than	du	Elementary/Secondary (0-12)	College (1-4or 5	i+)			ed)		£	1	1
d 2	filed v Hygia officer t		unknown 17. Fether's Neme (First, Middle, Lest,	unknown		clear	iiIiig	18. Mother's Nan	ne (First Middle		neral	nome
Maryland	should ba nd Mantal marked o	To Be	William Ambrose						rl Ambro		, , , , , , , , , , , , , , , , , , ,	
ary	2 shou and M is meri	-	19a. Informant's Name/Refationship (	Type, Print)		19b. Mailing A	ddress (Stree	t and Number or Ru	rel Route Numbe	r, City or	Town, State	, Zip Code)
	C M 01 F		Pat Pryor - frien	d and POA		72 Sur	nbrook	Lane, Hag	gerstown	, Md	. 2174	12
Baltimore,	8 6 = 2		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control		cen	ce of Disposition in the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contr	ory or other pla	ial Park	Date 8/25/04			or Town, State wn, Maryland
Balt	parmit. Page Dapartment important: If any injury or		21. Signature of Funeral Service Licer	Numi	M	/			NNICH FU			E Md. 21740
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ō	his his	<u>۾</u>	1 Yes 2 LNo 27. Manner of Death	1 L Inpatier		VOutpatient 3	DOW	41 Virtursing H	ome 5 Resid		, ,	ecify)
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	Hospi 24 hou Funer taly fill	edlcal	29a. Certifier (Check only one)	ysician: To the best of linar: On the basis of and manner stat	examination	edge, death occ n end/or investi	curred at the ti gation, in my	me, date end place, opinion, death occur	and due to the or red at the time, or	ause(s) a late and p	ind manner i place, and di	as stated. ue to the ceuse(s)
	To the within 2 To the comple	Σ	29b. Signature end title of certifier				29c. Licens				-	nth, Day, Yeer)
			Jung Mill	-, 25			Do	1040	(	38-	25-01	1
			30. Name and address of person who									
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3	Stat Registra		AUG 242			. Spe	SU.					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 17, GRAFF 2004 9:00 P. M LONNI JANET August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5042 Freter Road Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Yrs. Director 219-46-7155 58 26, 1946 California Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examiner hast be notified at Maryland Carrol1 Sykesville 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 5042 Freter 21784 U.S.A. Road or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other then "naturel", or Itel 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lonnie Powers Svlvia Vigderhouse ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre Mark Graff/ Husband 5042 Freter Road, Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 8/21/2004 Huntt Crematory Waldorf, Maryland 21. Signature of Funer vice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardia( Physician disease or condition resulting in death) /Medical Examiner 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-tran resulting in death) Last attending physician Box 68760 Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant I ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 r 1 Yes 2 ρ Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I the à signed t d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 Probably 4 □Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 🗌 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Deat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Injury Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 T Homicide within 24 hours a To the Funeref C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) the 29b. Signature and the of certifier DU0295 71 Who completed cause of death (Item 23a) (Type, Point)
SEREZ, MD 1655 CROFTON BLVD, CROFTON MD. 21114 31. Date filed (Month, Day, Year) State Registrar

	_	- Salario	1- For State of Maryland / Depa	rtment of Health and M	Reg.	0001 001
Ī	Physici /Medio	cal	Ruth G. Goodman		2. Date of Death Month August	3. Time of Death 1:44pm M
_	Examir Funeral	ier	4a. Fecility Name (If not institution, give street and number) Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Takoma Park  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Montgomery  9. Birthplece (State or Foreign County)
	Director		578-30-1597		Oct. 19,	9. Birthplece (State or Foreign Country) 1926 Florence, SC.
	r 28a-f sho	Funeral Director	D0		10g.	1 No Yes 2 No Citizen of What Country?
	a 23a o	eral D	5036 Sargent Rd. NE.	20017		United States
920	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "nature!', or liems 23a or 28s-f show event, Ire Medical Examiner must be notified at	þ	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I Yes 2 No Specify:	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	within 72 ho ene. then "netu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th  16a. Decede (Give k life. D	ent's Usual Occupation kind of work done during most of workin O NOT use retired) Dietician	ng 16b	o. Kind of Business/Industry  Government
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event, the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the Mental and the	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid Mae Skeet	den Sumame)
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Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 is marke eny injury or other traumatic 000.00.		20a. Method of Disposition  1			. Location · City or Town, State Arlington, VA.
Bait	permit. Departr Importe eny inju		Floria MD wis2	Name and Address of Facility Pol 617 Penn. Ave. SE	pe Funera . Wash, D	1 Homes
8/60,	Physician /Medical Examiner physician and physician and physician and physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street physician street phys	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or Injury that infriated events resulting in death) Last  Due to (or as consequence of):  Due to (or as consequence of):  Due to (or as consequence of):	shock.	rrespiratory arrest,	Approximate Interval Between Onset and Death
O. Box 6	ath certif attending for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ E	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Ŭ L	The la ate has page 2	Completed	CANCEL MILLERY	len	24a. Was an autopsy performed 10 es 20	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 140
ion of Vital	ding Phys  After this funeral di	ertification: To Be	25. Was case referred to medical examiner?  1			6 ☐Other (Specify)
DIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	O	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specity)		City or Town, St.	
	in 24 hou in 24 hou ihe Funel pletely fil	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or investigated.	occurred at the time, date and place, an astigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	with To	Σ	29b. Signature and title of certifier	29c. License number 56/14	7 29d. 1	Date signed (Month, Day, Year)
(	CR (4)		30. Name and address of person who completed cause of death (Item 23a) (Type, P Nasreen Kango, M.D. 7610 Carroll Ave.		20912	
	Sta Registr	_	31. Date filed (Month, Day, Year)  AUG 2 4 2004  22. Registrar's Signature			

			1 - For State Registrar	State of Ma	-		tment of Heificate of L		d Mental H	lygiene Reg. No.	004	28162
	Dhusisi		1. Decedent's Neme (First, Middle, Last	:)					2. Date of Month	Death Day	Yeer	3. Time of Death
	Physicia /Medic	al		Gerred			. 100 =		Augus		2004	9:10 p.m. ^M
}	Examin	er	4a. Fecility Name (If not institution, give				4b. City, Town, or		eath		ounty of Deeth	
			22748 Old Rolling 5. Social Security Number 6. Se		(In yrs. last bir	thdav)	Califor	nia If Under 24 h		Birth	t. Mary	plece (State or Foreign
	Funeral Director			M 2⊠F		Yrs.	Months Days	Hours N	Ain. (Month, Apr.	Day, Year) 26, 19:	Cou	ntry) ginia
	ס		Usual Residence of Decedent		10- 0'- Y-							Transaction of the second
	arylar ehow	_	10a. State 10b. County	•	10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 No
	Ra-f	Directo	Maryland St. Mar	'y's	Cali	forn	1a 10f. Zip Code		4	10g Citize	n of What Cou	
	a or	급	10e. Street and Number 22748 Old Rollin	ac Pond			20619				S.A.	
	ns 23	Funeral	11. Marital Status	12. Was Decedent F	Ever in U.S.	13. W	as Decedent of His	spanic Origin?	? (Specify Yes or		. Rece - Ameri	
20	or iter	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 N	lo		Yes, specify Cubar ☐ Yes 2X☐ No	n, Mexican, Pi Specify:	uerto Hican, etc.)		Black, White,	
ğ	filed within 72 hours after death with the Maryland Hygiene. other than "naturel; or tlems 23s or 28s-f show out, the Madical Examinet must be notified at	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		'	1 195 210 190	Зреспу.			pecify: Whi	
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	16a.	(Give ki	nt's Usual Occupa nd of work done d D NOT use retired)	uring most of	working	16b. Kind	of Business/Ir	ndustry
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an	ould be Mental I	To B	Irving Wade Deane	<u> </u>				Mary	Kenda11	Mitche	e11	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23a or 28a-f show eny injury or other traumatic event, the Modical Exercities mast be notified at once.		19a. Informant's Name/Relationship (7	ype, Print) Daug	hter 19b	. Mailing	Address (Street a	nd Number o	r Rural Route Nu	mber, City or T	own, State, Zi	p Code)
	and 2 salth a n 27 i		Katherine Gerred V	larren			Silk Oa			-	_	
altimore,	of He of He Hiter		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	f Disposi ry, crema	tion (Name of atory or other place	9)	Date	20c. Loca	tion - City or T	own, State
<u>E</u>	Pag tment tant:		4 □Donation 5 □Other (Specify	)	Ebene		Cemetery		-30-04			ark, MD
Bai	Depariment Department Importment		21. Signal and Inneral Service Ucen	つわ	(0111/							me, P.A.
	Physician		Mary RIZO  23a. Part 1. Enter the disease, or corporation of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of t	A	/ 13	not enter		g, such as car			vii, mar	y1and 20650 Approximate Interval Between Onset and Death
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			3C DOA Othe	200	Death (Check on	-	7011 10	· · · · · · · · · · · · · · · · · · ·
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	ne Hospito 124 hours 10 Funere 11etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	f examination ar	e, death nd/or inve	occurred at the timestigation, in my op	ne, date and p pinion, death o	place, and due to to occurred at the time	he cause(s) and p	nd manner as s lace, and due	stated. to the cause(s)
ı	To the within To the	Me	29b. Signature and title of certifier				29c. License		701	29d. Date	signed (Month	Dey, Year)
)	0		1 0/5	CCI	0		MUC	000	751	8,	100/	7
6	700		30. Name and agoress of person who									
			Jennifer Schmidt	, M.D. 2	3415 Thr	ree 1	Notch Roa	ad Cali	lfornia,	Maryla	nd 206	19
	Sta Regist	ate rar	31. Date filed (Month, Danger 8	1 2004 Hegis	ar's Signature	15	( Spends					

		1	For State	State of Maryla	•	artment of He rtificate of De		ental Hygier Reg. I		00160
			Registrer  I. Decedent's Name (First, Middle, Last	1		incare or D		2. Date of Death	10.	3. Time of Death
	Physicia /Medic	เก		M. GREEN	E			AUGUST	15, Yeer 200	
	Examin		a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Lo			4c. County of Dear	
			3123 1222	ENUE		COLMAR  If Under 1 Year		3. Date of Birth		GEORGE S
	Funeral		5. Social Security Number 6. Se	TH METE	rs. last birthday) 5.6 Yrs.		Hours Min	(Month, Day, Yea	948 W	thplace (State or Foreign puntry)
	Director	<u></u>	577-66-7990 Usual Residence of Decedent		56_ Yrs.			lay 20, 1	940 W	asii., D.C.
	land ow		10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	Many f sh	ξ	Md. Prince	George's		Colmar M	anor			1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	h with	O E	3903 Newark Roa	d		2	0722		United S	tates
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. It was 23a or 28e-f show item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Medical Extending counties and the nutified at	y Fu	1 ☐Never Married 2 ☐ Married	1 □Yes 2 No If Yes, Give			Specify:	,,	Specify: B1	
21215-0036	urel',	d b	3 Widowed 4 Divorced	Year or Dates:	160 Deep	dent's Usual Occupati		16h	. Kind of Business	
15	"net	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(Give	kind of work done dui DO NOT use retired)	ring most of working	9	Killa of Basillosa	·
12	filed within Hygiene.	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	Admin	istrative	Assistant	t I	Private	
	filed Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)			1		(First, Middle, Maid	len Sumame)	*
Maryland	Mental Merked o	To B	John Greene				Mary	Metcalf		
ary	2 should and Men is marks reumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street an	d Number or Rural	Route Number, Cit	y or Town, State,	Zip Code)
	alth alth		Cheryl T. Wade		3413	and the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of th		ar Manor,		722
ore.	of He of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	I	o. Place of Dispo cemetery, crea	osition (Name of matory or other place)	I		Location - City or	
Ĕ	Page nent ent: i		4 □ Donation 5 □ Other (Specific	F	1 6	oln Cemete			Brentwoo	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 li eny injury or other tre 9008.		21. Signature of uneral Service Liber	shirt I	alley 1	2. Name and Address 425 Maryla	ind Ave.,			Inc. 0002
			23a. Pann. Enter the disease, or congression, or heart failure. List only	lications that crused the de	eath. Do og en	ter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	Milian	irell					Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	00	Phree nech			
М	Examine		Sequentially list conditions, if any, leading to immediate	b. Due to or as a cons	une	2 Ca	neen			
	ed sit	Examiner	rt any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to tot as a cons	sequence on.					
^	axecur and al-trar	xar	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	cate be executed physician and s the burial-transit	dicai	l	d						
89		a								-
Вох	death certific e attending p od for use as	M/M	23b. was decedent pregnant	23c. If yes, outcome of pre	gnancy etel death 3 [	☐Ectopic pregnancy			23d. Date of de Month	livery Day Year
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of		Other (specify)			Wichter	Day Tour
P.0	at the de d by the etached	Phy	9 ☐ Unknown  Part II. Other significant conditions of	antichation to death had not	roculting in the I	andorhina anuco aixon	in Part I	23e Did tobaco	co use contribute t	o the cause of death?
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orc	w require been si should b	eted						24a. Was an		utanou findinga available
of Vital Records,	e law has b	Completed						autopsy performed	prior to death?	utopsy findings available completion of cause of
a F	sien: The law artificate has I ctor, page 2 s							1  Yes 2	No 1 ☐ Yes	s 2 No
Vit.	- 3 E	Be	25. Was case referred to medical examiner?	Hospital:	C 50/0 +	Other	26. Place of Death	(Check only one) ne 5 ☐ Residence	e Mother (Co.	ecity) Daughter
ō		5 1	1 Yes 20 No 27. Manner of Death	28a. Date of Injury	28b. Time of			8d. Describe how in		Residence
	ding I th. After funer	tlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		s 2 □No			
Division	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	286. Place of filluly - A		reet, factory, office	2	8f. Location (Stree) City or Town, St		tural Route Number,
ă	s after	Certification:	4  Homicide	building, etc. (Spe	ocity)			0.1) 0		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (	(Check only   Medical Exen	ysicien: To the best of my niner: On the basis of exam	knowledge, dea nination and/or in	th occurred at the time evestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	thin 2 the complete	Med	29b. Signature and title of settifier	and manner stated.		29c. License	number	29d.	Date signed (Mon	th, Day, Year)
	F 3 F 8		X	JL600.		NA	914	2	8/14	204
^	0 2		30. Name and address of person who	completed cause of death (	Item 23a) (Type	, Print)	-110		0.6	
4	(3)		Charles Boice 31. Date filed (Month, Day, Year)	, M.D. 1030	01 Georg	gia Ave. S	te. 205	Silver Sp	oring, Mo	1. 20902
	St: Regist		ALIG 2 3 200		-					

		Registrar  1. Decedent's Name (First, Middle, La		00	artment of 1- 35 09/03/ rtificate of	Dealli	2. Date of Dea		14 281		
Physici /Medic	cal		izabeth	Gorman	4h City Town o	Location of Death	August	20, 200 4c. County			
Examin	ner	6807-C Mountain				erick		1			
Funeral				e (In yrs. last birthday		If Under 24 Hrs.					
Director		142-30-3607 Usual Residence of Decedent	1□M 2ØF	72 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) Nov 26	, 1931_	9. Birthplace (State o Country) Germany		
Marylan e-f show	tor	Maryland Frederi	.ck	10c. City, Town or L Freder:					10d. Inside Ci		
th with the 23a or 28 Ist be not	ai Dire	10e. Street and Number 6807–C Mountaind	lale Road		10f. Zip Code	21702		10g. Citizen of V U.S			
int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heeth and Mental Hygiene. A stransit if term 27 is marked other than "natural; or itema 28a or 28a-f show injury or other traumatic event, if a heatest Examinar must be notified at the second of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract o	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specifi	ee - American Indian, ck, White, etc.		
hin 72 ho e. en "natur	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work ()	sing	16b. Kind of B	usiness/Industry		
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f and 2 should Heelth and Men em 27 is marke ither traumatic		19a. Informant's Name/Relationship Lillian Fergusor			ng Address (Street a				State, Zip Code) , MD 21702		
Pages 1 a nent of Her int: if item iry or othe		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	θ)	Date		City or Town, State		
permit. Pages 1 and Department of Heelth Important: if item 27 any injury or other tr		'4 □ Donation 5 □ Other (Special Signature of Funeral Service Lide	(y)		t Cemeter				ck, Maryla		
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nysician /Medical		disease or condition resulting in death)		arcinoma d	of colon				years		
te be executed ysician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Fuphy S  Due to (or as a	a consequence of):  ema a consequence of): a consequence of):					years		
The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat	e of delivery nth Day Y		
urres than signed I	þ	Part II. Other significant conditions Ascites; Osteo				on in Part I.			ribute to the cause of de		
ine iaw requisete has been page 2 should	Completed	Alcohlism; Ort	_		•		24a. Was a autops	SV C	Were autopsy findings a prior to completion of ca leath?		
rnysician: In this certificate ral director, pag	Be Co	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes a		Yes 2 No		
ng Pnys fter this ineral dii	tion; To	1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier y 28b. Time o (Year) Injury	f 28c. Injury Work	at	me 5 Reside 28d. Describe ho				
after death. Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	e 20a Diesa of Inju	ry - At home, farm, st . (Specify)			28f. Location (St City or Town	treet and Numbe n, State)	er or Rural Route Numb		
io to ne nospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best on niner: On the basis of and manner stat	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the cause(s)		
within To th comp	Me	29b. Signature and ottle of certifier	1.11	4	29c. License	number	2	9d. Date signed	(Month, Day, Year)		
		Illen K	elly	MO	D547	49		August	23, 2004		
	1 1	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type.	Print)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year DANIEL **JARVIS** HITLE AUGUST 22 2004 4:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 220-28-0315 Director 2 1932 Aug Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r then "netural", or items 23a or 28e-f show the Medical Experiment must be notified at 10d. Inside City Limits Director 1X Yes 2 No MD Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11955 Augustine Herman Hwy. 21645 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: <u>م</u> 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner - Operator Retail Appliances Ith and Mental Hygie 27 is marked other treumatic event, marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be outd be f Mental Daniel Raymond Hill Mabel A. Jarvis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree Geri Stubbs (daughter) 304 Quail Run Dr. Centreville, MD. 21617 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Still Pond Cemetery 8/26/04 Still Pond, MD. 21. Signature A Funeral Service License Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MODRLY METASTATIC DIFFERENTIATED) CARCINUMA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) o detached 9 Unknown ል يَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed CENEYRO NASCULA Accident 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? has Vital 1□ Yes : After this certifications a funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director; the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide after To the Hospitel or within 24 hours a

To the Funerel C

completely filled i 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 123/0X D006030 30. Name and address of person to comp cause of death (Item 23a) (Type, Print) ducither & Himm, MD 122 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32. Registar's Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 4 2004

			For State	State of Maryla	•	tment of H			0001	00167
			State     Registrar     Decedent's Name (First, Middle, Lat.)	st)	Certi	iicate Ui L	- Jean	2. Date of De.	Reg. No.	3. Time of Death
	Physici /Medio	al	Urs Hiltiker					HIGHSI	700	)4 VII DM
4	Examin	er	4a. Facility Name (If not institution, give	e street and number)	Center "	b. City, Town, or	Location of Deal	in J	4c. County of De	ath
	Funeral		5. Social Security Number 6. S	ex 7. Age (In ye		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 9. B	irthplace (State or Foreign Country) Switzerland
	Director		097-42-9033 Usual Residence of Decedent	-X 5	9 Yrs.			April	29, 1945	Switzerland
	anyland show	_	10a. State 10b. County		City, Town or Loca					10d. Inside City Limits 1 ☐ Yes 2 ☐ No.
	the M	by Funeral Director	Maryland Kent  10e. Street and Number		Rock Hal	10f. Zip Code			10g. Citizen of What	A
	23a or	ral Di	5150 Skinner	·			1661		Switzerl	
	ter dea	une	11. Marital Status 1 ☐ Never Married 2 【XMarried	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ Wo				Specify Yes or No to Rican, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, nite_etc. White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ta Medical Exarction mat be notified at	d by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 [	Yes 2□No	Specify:		Specify:	
15-0	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	16a. Deceder (Give kir life. DC	nt's Usual Occupa nd of work done d O NOT use retired)	ition uring most of wo	rking	16b. Kind of Busines	ss/Industry
212	giene. er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 6	Archi	tect				tecture
and	d be file	Be	17. Father's Name (First, Middle, Last, Rudolph Hilfike					ma <i>(First, Middla,</i> ofstette	, Maiden Sumame) T	
Maryland	shouk and Me s mark umatic	To	19a. Informant's Name/Relationship (	Type, Print)					er, City or Town, State	
6, ₹	and 2 dealth a sm 27 I		Lynn Barrett Hi		5150 D. Place of Disposit		s Neck	Road Koc	k Hall, MD	
mor	ages ent of H nt: If ite ry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐  *4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crema CHesapeak	tory or other place		r 8/22	Stevensvil	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic event, If a Medical Examination must be rollified at once.		21. Signature of Funeral Service Licer			Name and Addres		n, & New	nam Funera	1 Hone PA
			23a. Part1. Enter the dise se, or comshock, or heart failure. List by	plications that ceused the done is use on each line.	eath. Do not enter	the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
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8760,	0 0	dicai	•	d						
Вох 68	leath certificat attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of c	lelivery
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown		ctopic pregnancy Other <i>(specify)</i>			Month	Day Year
, P.O	requires that the deen signed by the	y Phy	Part II. Other significant conditions	contributing to death but not	resulting in the und	erlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Records,	w requires been sign should be	ted by						10	Yes 2 No 3	Probably 4 Munknown
Seco	law as b	ompieted						24a. Was autoj	an 24b. Were prior to death	autopsy findings available o completion of cause of
Vital F	Ician: The certificate ha	C	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2 <b>1</b>	
of Vi	S S	To B	examiner? 1 ☐ Yes 2 █ No		ER/Outpatient	3□ DOA Othe	er: 4 Nursing	Home 5 ☐ Resi	dence 6 □Other (S)	pecify)
o uo	ling After une	tion:	27. Mann of Death  1	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	rat ?? Yes 2 □ No	28d. Describe	how injury occurred	
Division	al or Attending safter death. I Diractor: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide de ermined	De Place of Injuny - A	t home, farm, stree	et, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
_	splta ours era	edical Ce		hysician: To the best of my miner: On the basis of exam and manner stated.						
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	· IN B	or doxt	29c. License	number		29d. Date signed (Mo	nth, Day, Year)
,			ON MAN CONTRACTOR	4 /1/W, / 16	Itom 22a) /Time D	120	12	9	Jugust 1	1,2007
			30. Name and address of person who	completed cause of death (	BATA	nd 55	Ata	Bak	imare, M	D 51530
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Coade 10			,	

			State of Maryland / Department of Health and Mental Hygiene State Registrar  Certificate of Death  Reg. No.?
	Physici /Medi Examir	cal	Pegistrar  Developnt's Name (First, Middle, Last)  PRODUCTION OF Location of Death  Day  Year  J. Date of Death  Month  Day  Year  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Date of Death  J. Day  J. Day  J. Day  J. Day  J. Day  J. Day  J. Day  J. Day  J. Day  J. Da
e .	Funeral Director		Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Number  1 Number 24 Hrs.  Months Days Hours Min.  Feb. 3, 1918  9. Birthplece (State or Foreign Country)  Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified alonge.	To Be Completed by Funeral Director	Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust   Sust
8760,	Physician /Medical Examiner /Medical Examiner	icai Examiner	130 Speer Road, Chestertown, Maryland 21620  3a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
Records, P.O. Box 68	wrequires that the death certific een signed by the attending p hould be detached for use as	Completed by Physician/Medi	FEMALE: bb. Was decedent pregnant in the past 12 months? 1
Division of Vital I	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be Co	Was case referred to medical examiner?    1   Yes   2   No
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	Medical Ce	ta. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  27c. License number  27c. License number  27c. License number
5.5	Sta Registr		Name and address of person who completed cause of death (Item 23a) (Type, Print)  KIN K. WUN, 415 Washington Acc., Chestertown, MD 21620  Date filed (Month, Day, Year)  AUG 2 4 2004  AUG 2 4 2004  AUG 2 4 2004

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			For State	State of Ma	aryland						2.0	nI.	20160
			Registrar				rtificate o	Deau		2. Date of Deatl	g. No U	UH	20109
	Physicia	an	1. Decedent's Name (First, Middle,	Adian ( )		1060				Month	Day	Year	3. Time of Death
	/Medic	al	VINCENT	HWHMONY	MY	nsc		and continu	of Dooth	Hugus-	4c. Count	2004	2210 PM
	Examin	er	4a. Facility Name (If not institution,	1 110	أمليت		4b. City, Town		1	,	1 4 4	ent	1
100		≪ "		Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Yes		or 24 Hrs.	8. Date of Birth		_	nplace (State or Foreign
	Funeral Director		214-66-9239	1 <b>⊠</b> M 2□F	49		Months Day	/s Hours	Min.	8. Date of Birth (Month, Day, August	Year) 2.1955	Col	ryland
57.3	- 445		Usual Residence of Decedent				1			1108000	_,		Ly Iuna
	nylan how		10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City Limits
	e Ma le-f	cto	MD Kent	<u> </u>	Ches	terto	wn						1 ☐ Yes 2 📉 No
	death with the Maryland ms 23a or 28e-f show	Director	10e. Street and Number				10f. Zip Code	Э		10	g. Citizen of	What Co	untry?
	23a	ral	21931 Tolcheste	er Beach Roa	ıd		216				USA		
	tems	Funeral	11. Maritai Status	12. Was Decedent Armed Forces?		13.	Was Decedent of If Yes, specify Ci	of Hispanic O uban, Mexica	rigin? (Spec an, Puerto F	cify Yes or No- Rican, etc.)		ice - Amei ack, White	rican Indian, a, etc.
36	hours after tural', or Ite al Examina	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give A Year or Dates:	10		1 ☐ Yes 2🌠 N	lo Specify	y:		Speci		1_
3	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or flems 23a or 28e-f show awant, the Madical Examiner must be notified a		15. Decedent's			16a. Dece	dent's Usual Occ	cupation			6b. Kind of E		ack ndustry
Ċ	in 72 n "na	piet	(Specify only highest	grade completed)		(Give	kind of work don DO NOT use reti	ne durina ma	st of workin	g	00. 14.110 0. 1		
7.7	filed within 72 Hygiene. other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Τe	acher				Edu	cati	on
0	i Hyg other	Be C	17. Father's Name (First, Middle, La	ist)				18. Moth	her's Name	(First, Middle, N	faiden Suma	me)	
<u>a</u>	should be nd Mental marked o	To B	Franklin Allen	Hynson Sr.					Rebec	ca Viol	et Gri	.nne1	1
Maryland 21215-0036	R D E E		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Stre	et and Numi	ber or Rural	Route Number,	City or Town	, State, Z	ip Code)
	and 2 Balth a n 27 ls		Frances Grinnel	ll Harman/s:	ister	1826	Swanse	a Road	1, Bal	timore,	MD 21	239	
ē.	s 1 and of Heal item		20a. Method of Disposition		20b. Plac	ce of Disponetery, crei	sition (Name of matory or other p	olace)	Dá	ate 2	0c. Location	- City or 1	Town, State
Ĕ	Pages nent of ent: If it any or o		1 ☐ Burial 2 ☐ Kremation 3  `4 ☐ Donation 5 ☐ Other (Spe			-	e Crema		08/1	8/2004	Steve	nsvi	11e, MD
Baitimore,	orte inju		21. Signature of Funeral Service Li	censee	1.	_	. Name and Add	dress of Faci	lity				
n	Depa Impo		1 Krik of	Hulh	the		130 Spe	er Roa	ad, Ch	esterto	wn, M	D 2	Home, P.A. 1620
			23a. Part1. Enter the disease, or coshock, or heart failure. List of	omplications to a caused by one cause are each li	the death.	Do not ent	er the mode of d	tying, such a	s cardiac or	respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MATA	STAT	70	Colu	سرر	CAN	CEY		1	Onset and Death
15	/Medical		resulting in death)	Due to (or as	a conseque	nce of):							
Ш	Examiner		Sequentially list conditions,	b									
-	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nea Ut).							
	ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c									
,60,	be executed ician and burial-transit		resolding in Goddin Last	Due to (or as	a consequer	nce or):							
687	ys 9	dlcal		d								_	
	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of prognanc								
Rox	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	eath 3[	Ectopic pregnar					ate of deli- onth	very Day Year
o.	Q 0 Q	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	lime or deal	ui st	Other (specify)						
٦.	The law requires that the ste has been signed by the bage 2 should be detache	H.	Part II. Other significant condition	s contributing to death b	ut not resulti	ing in the u	nderlying cause	given in Part	ıl.	23e. Did tob	acco use cor	ntribute to	the cause of death?
Records,	signed I	d by								1 ☐ Ye	s 2.2 No	3 □ Pro	bably 4 Unknown
Š	w require been sign should b	Completed								24a. Was an	245	Mara au	topov findings available
ĕ	has has	ш								autopsy	,	prior to c	topsy findings available ompletion of cause of
			00.14	- T							No	1 🗆 Yes	2 No
Vital	Physicien: The this certificate had ald director, page	Be c	25. Was case referred to medical examiner?  1 Yes No	Hospital:	- 2051	R/Outpatier		Other		(Check only one		h (C	
ö	Phys r this ral di	. To	27. Manner of Death	1 Inpatie	ry 21	8b. Time o				ne 5 🗌 Reside 8d. Describe ho			iry)
o	ding I th. : After s funer	ig i	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year)	Injury		Vork? □Yes 2□	□No				
Division of	l or Attending F after death. Director; After I in by the funer	fica	3 ☐ Suicide 6 ☐ Could no	ed 286. Place of Inj	ury - At hom	e, farm, sti	eet, factory, offic	се	2			ber or Ru	ral Route Number,
	al or after	Certification;	4 Homicide	building, et	c. (Specify)					City or Town	State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge, deat	h occurred at the	time, date a	and place, a	nd due to the ca	use(s) and m	anner as	stated.
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical E.	xaminer: On the basis o and maneer st	i examination ated.	n and/or in	vestigation, in m	y opinion, de	eath occurre	d at the time, da	te and place	, and due	to the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	05/		M	29c. Lice	ense number			d. Date sign		
			> / Mule	el 15		10	7 0		603	•	8/1	-	•
			30. Name and address of person w	ho complete cause of c	eath (Item 2	За) (Тур	Print)	C. D		C ~			, VW) 21620
			1.0-1	IMEN NO	199		en Po	)00	43	UT125/	FK19	w	1 (M) 9(09a
	Sta Registi		31. Date filed (Month, Day, Year)	9 2004 32. Regi	ar's Signatur	re 🌬	1						
		~ Y 2	13111-1	J CUUT BEST	BEETAAR A	N. K.	Managarit "						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) August 24, 2004 8:15 РМ Mary C. Hudson 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charles Waldorf Health Care Waldorf If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 10, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F 66 Yrs. 579-50-8772 1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. Count 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11610 Teagues Point Road 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🕻 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Elmer Stonestreet Frances Mabel Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38406 Arlington Drive, Mechanicsville, MD 20659 <u> Tony Hudson - Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 8-27-04 * 4 ☐ Donation 5 ☐ Other (Specify) Bryantown, MD 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Signature of Funeral Service Licenses M00053 Tau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a, State

**Funeral** 

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Ia marked other than "natural", or Items 23e or 28a-f show

I Hygiene.

jo i

Department of Importent: If any injury or once.

Baltimore, Maryland 21215-0036

item 27 la marked other than "natural", or items 23e or 28a-1 show other traumatic event. It a Mcdical Examiner must be notified at

Completed by Funeral Directo

Be ပ

use as the burial-transit

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after death.

completely within 2 To the I

State

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Re Completed filled in by

Sequentially list conditions, it may be supplied to the cause. Enter Underlying	Due to [or as a cons	uence of):			
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1  Live birth 2  Fete 4  Pregnant at time of c 9  Unknown	at death 3 □Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlyi	ng cause given in Part I.		pacco use contribute to the cause of death? es 2⊕No 3□ Probably 4□Unknow
				24a. Was an autops perform	prior to completion of cause of death?
25. Was case referred to medical examiner?				eath (Check only one	θ)
1 ☐ Yes 2 ☐ No	lospital: 1 🗌 Inpatient 2 🗀	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Reside	ence 6 Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fac fy)	ctory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, n, State)
29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Examin	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and pla- tion, in my opinion, death oc-	ce, and due to the ca curred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
29b. Signature and title of certifier	MD		29c. License number D 5 2 2 8		9d. Date signed (Month, Day, Year) 8/25/2004

10 St. Patrick's Dr. #404 WALDORF, MD 20603

DHMH 17 Rev 1/2001

MPU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 6 2004

31. Date filed (Month, Day, Year)

MATHUR, MD

Meles

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) P_M **Physician** August 17, James Leonard Hall 2004 9:15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Leonardtown Saint Marys St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 84 Yrs February 12,_1920 214-30-6891 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show ral', or items 23a or 28a-f shov Examinat must be notified at 1 ☐ Yes 2√√No Directo Bushwood Maryland Saint Marys 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22114 Coltons Point Road 20618 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene, important: if item 27 is marked other than "natural", or iten important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exams and appe. 1 ☐ Yes 2XXNo If Yes, Give 1 Never Married 2XXMarried 1 Yes 2XXNo Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leonard Hall Myrtle Virginia Knott ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Louise Hall / Wife 22114 Coltons Point Road, Bushwood, Maryland 20618 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery August 20,2004 Bushwood, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Fune a Record Licens P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Setwe Onset and De Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions if any, leading to innicially cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ed bluods 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed' 2 No certificate 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification: After Injury 5 Pending 1 Natural 1 Tes 2 No death. investigation 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier oc/ of death (Item 23a) ( 30. Name and address of 24085 Three Notch Road, Hollywood, Maryland 20636 Dr. James P. Jarboe M.D. 31. Date filed (Month, Day, Year) State AUG 1 9 2004 Registrar

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** William Battaglia HORN 8:35 A M AUGUST 21 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 26400 Peninsula Drive Hollywood St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 5,1921 Birthplace (State or Foreign Country)
 New York 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 83 060-14-1535 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 7 ie marked other than "natural", or iteme 23a or 28a-f show traumatic event, II.a Medical Evar it ar mast be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20636 26400 Peninsula Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₹₹/es 2 □ No If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 25 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Government Contractor Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Horn ဨ Louis Cyrus Battaglia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st. Department of Health and Important: if item 27 ie m eny injury or other traum once. Maria C. Perrygo/Granddaughter 25683 Jones Wharf Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) August 23, Metropolitan Crematory 2004 Alexandria, Virginia 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Sovice Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician New and Tancylo disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed use as the burial-transit stelio and Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 1 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 4NO 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient this 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spate(s). 29a. Certifier (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Dav. Year) SAP 5 who completed cause of death (Item 23a) (Type, Print) Dr. J. S. Tidball, 23415 Three Notch Road, California, Maryland 20619 32. Registrar's Signature 31. Date filed (Month. Day, Year) AUG 2 5 2004 Registra 2 Comment

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30	Physici /Medio	al	1. Decedent's Name (First, Middle, Las	HENL	EY	ity, Town, or Location	2. Date of Month	Death Da		3. Time of Death 5.54 PM
	Examin Funeral Director	er	PRINCE GEORG 5, Social Security Number 6, S	ES HOSP. C	TR	CHEV	ERLY	Birth Day, Year	RINCE (	SEOKES place (State or Foreign intry) Ch Carolina
	Maryland I show	tor	10a. State 10b. County		ry, Town or Location Springdale					10d. Inside City Limits 1 □ Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 9103 Utica Place		10f.	Zip Code 2077	4		itizen of What Cou	intry?
980	be filed within 72 hours after death with the Maryland stal Hygiene.  do other than "netural", or items 23e or 28e-f show avent, the Medical Evaring must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ecedent of Hispanic ( specify Cuban, Mexic s 2 No Specif	Origin? (Specify Yes o can, Puerto Rican, etc. fy:	r No-	14. Race - Amen Black, White Specify: B1a	, etc.
1215-0	within 72 ho ene. than "netur he Medical i	Completed	15. Decedent's E. (Specify only highest gra		life. DO NO	work done during m T use retired)	ost of working		Kind of Business/Ir	
Maryland 21215-0036	ould be filed within Mental Hygiene. arked other than a atic avant, me We	To Be Co	17. Father's Name (First, Middle, Last) Unknown		Clerk Ty	18. Mot	ther's Name (First, Mic ggie Worts		Governmen n Sumame)	חנ
	nd 2 shoulth and 27 lem	To and the	19a. Informant's Name/Relationship ( Raymond Henley/H	lusband	9103 Uti	.ca Place	nber or Rural Route No Springdale			
Baltimore,	permit. Pages 1 at Department of Hea Important: If item eny injury or oths:		20a. Method of Disposition  13 Burial 2 Cremation  4 Donation 5 Other (Specific	Han	Place of Disposition (cometery, crematory)	tery	8/27/04	Land	dover, M	aryland
Bal	permit. Pa Departmer Important eny injury		21 Signature of Funeral Service Licer  23a. Pan 1. Enter the disease, or com		7474		Rd. Landov	er, Ma	ns Funera	
	Physician /Medical Examiner	ner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	a. Ventro  Due to (or as a consequence)  b. Sepsi	culor Fi			, 4.1031,		Interval Between Onset and Death
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Zit.	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatient 2 M	ER/Outpatient 3	Other	ice of Death <i>(Check or</i> Nursing Home 5  F		e Cothar (Cara	6.3
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	ithin 2 tha omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License numbe	r	29d. Da	te signed (Month,	Day, Year)
			> 50m	MD.		D620	57		8/20	12004
ρ	RD		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	5000-00	ilan Ci	30	XXI HOS	pital Disc
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9	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖄 No	10.				i, Puerto I	cify Yes or No Rican, etc.)		Black, Whi	te, etc.
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ylaı	should be and Mental marked o	To	Andrew Lee	wa wa					Anna	a Graha	am		
Maryland 21215-0036	0 0 0		19a. Informant's Name/Relationship (1									or Town, State,	Zip Code)
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Baltimore,	permit. Page Department Importent: If eny injury or ance.		21. Signature of Funeral Service Licen									lomes, P	
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of	y s	. To	1 ☐ Yes 2 No 27. Manner of Death		2 ER/Outpatier			4 Nur				6 ☐Other (Spe	cify)
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Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely lilled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory,	office		2	8f. Location ( City or To			iral Route Number,
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01	(5)		30. Name and strings of person who of	completed cause of dea	th (Item 23a) (Type,	Print)	ex	XAn	MOE	RE	L	· MK	ott, mo
	- CY	to	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	Leve	nda	XC_	M	U, 20	073	37.	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Rebecca Hylton 17 August 2004 5:51p^v /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 ☐ M 2 🔀 F 82 213-43-8698 **Director** 1922 Jamaica Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 1 Yes 2 □ No Director Montgomery Maryland Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7507 16th Avenue 20912 Jamaica Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced Black Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Domestic and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be t and Mental h Benjamin Edwards Elizabeth Hayles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an Valerie Rochester/Daughter 7507 16th Avenue, Takoma Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 Themoval from State 4 □ Donation 5 □ Other (Specify) Church Pen Cemetery 8/21/2004 St. Catherine, Jamaica 22 Name and Address of Facility Alexander S. Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD 21. Signature of Funeral Service Licensee 20747 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician ue to (or as a cons+ your disease or condition resulting in death) one de /Medical ince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ₺ No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 NER/Outpatient Certification: To 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dec. 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 18895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE340, TAKEMA PAR 7610 CARRULL AVE, MOBARAK KARIM, 31. Date filed (Month, Day, AUG 2 0 32. Registrar's Signature State Registrar

			For Stata Registrar	State of Marylar		rtment of F tificate of		Mental Hy	giene Rag. No.	0.01	20176
	Physici		1. Decedent's Name (First, Middle, La Preston J	ames Hil	1	***************************************		2. Date of De Month Augus	eath Day	Year 2004	3. Time of Death
}	/Medic Examin Funeral Director		4a. Facility Name (If not institution, given the legion) 5. Social Security Number 6. S	re street and number)	nter	4b. City, Town, o	If Under 24 Arrs Hours Min	th  8. Date of Bi	4c. C	County of Death	
	Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wic		ty, Town or Loc					1	0d. Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Number 1017 Cecil S	t.		10f. Zip Code	804		_	en of What Coun	try?
980	i 72 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show cilical Evantination must be notified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∰ Yes 2 □ No Na If Yes, Give Year or Dates: WW	.Vy	/as Decedent of H Yes, specify Cuba □ Yes 2 No	ispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)		4. Race - Americ Black, White, of Specify: W	
121215-0036	nat Inat	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give k life. D	ent's Usual Occup ind of work done of O NOT use retired Defite	during most of wa 1)		P1	of Business/Ind	Justry
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	and 2 sho salth and n 27 le m		Lois Emily Mac	e Hill/wife	101	Address (Street					
Baltimore,	permit. Pagas 1 and 2 Department of Health s Important: If item 27 it any injury or other tra		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Removal from State	Place of Dispos cametery, crem. LCOMIC BIK	ition (Name of atory or other place O Memor	ial 08	Date / 12 / 04		ation - City or To	
Balt	permit. Depart Import any inj		Signature of Funeral Service Lice		#C S\$ 150	Name and Address 11 Oway 1 Snow	sset Facility Funera Hill R	l Home	Pro	fession	nal Asso
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplication that caused the deat one cause on each line.	h. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	contributing to death but not res	ulting in the und	derlying cause give	en in Part I.			contribute to the	e cause of death?
al Records,	: The law requicate has been page 2 should	Completed						24a. Was autoj perio 1 🗆 Yes		prior to com death?	esy findings available apletion of cause of 2 \( \sum \) No
f Vital	Phyaiclan: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatient	30 DOA Othe	200	ath (Check only of		Other (Specify)	)
Division of	To the Hospital or Attending Phyalcian: The law requires that the death certificate be executed within 24 hours atter death. with the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  2 Homicide  2 Pending investigation of Could not be determined	DO Disco of laws At h	28b. Time of Injury			28d. Describe	now injury of street and I		
	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno minar: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	e, and due to the arred at the time,	cause(s) ar date and pl	nd manner as sta lace, and due to	ited. the cause(s)
)	To th To th comp	Me	29b. Signature and title a certifier	Jamel		29c. License	number //8/		29d. Date :	signed (Month, D	'ay, Year)
VA Da			30. Name and address of person who	LK.AG	ARW		614 E	93/in-56	<i>9</i> ,	w. Sale	buy
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	4	/				100)	21801

/Medi	ian	1. Decedent's Name (First, Middle, Last) Bernard Thom	as Hiltner			2. Date of De Aug •	7, Day 2004 Year	3. Time of Dea 10:15 F
Exami		4a. Facility Name (If not institution, give s Vindabona Nur			y, Town, or Location of De addock Hgt		4c. County of De Frede	ath
Funeral Director		5. Social Security Number 6. Sex 214-10-5484 W  Usual Residence of Decedent	M 2□F 7. Age (In yrs. las	Yrs. If Und Month	er 1 Year   If Under 24 H s Days Hours M	in. 8. Date of Billin. (Month, Da May	18, 1917	irthplace (State or For Country) MD
ta-f show	ctor	MD 10b. County Freder:		Town or Location efferso	n			10d. Inside City Lin 1 ☐ Yes 2 ☐
23a or 28	Funeral Director	10e. Street and Number 5914 Broad Run	Rd.	10f. 2	21755		10g. Citizen of What C	Country?
other traumatic event, the Medical Exponent must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? W • V 1 XYes 2 □ No V If Yes, Give Year or Dates: II	V . If Yes, sp	edent of Hispanic Origin? ecrify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or No erto Rican, etc.)		nerican Indian, lite, etc. White
Hygiene. other than "natu ent, the Wedical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT Steamf	ual Occupation ork done during most of v use retired)  itter	vorking	16b. Kind of Business Federal	ŕ
and Mental Hygiene. I marked other than umatic event, the M.	To Be C	17. Father's Name (First, Middle, Last)  Howard S. H			18. Mother's N	h Baxte		
Health and lem 27 is ma other trauma		19a. Informant's Name/Relationship (Type Robert Hiltner	(Son)	19b. Mailing Addres 7603 Ma	rker Rd.,	Rural Route Numb Middlet	er, City or Town, State, OWn, MD	Zip Code) 21769
nent o		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ Re  1 ☐ Dopation 5 ☐ Other (Specific)	Mt.	pe of Disposition (National Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contr	Cemetery	Date 8/11/04	20c. Location · City of	
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fter death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be de	edical Certification; To Be	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Physic	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home	Injury M  o, farm, street, factor	1 ☐ Yes 2 ☐ No  y, office	City or Tow	n, State)	
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	, ,		Amend Item #5	State of Maryland			•	•	
,	•		1- For America I Cem #7	per in Gosy 9	Certific	ate of Death		3. No.2 11 11.	29170
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Stella Frances	Irwin			Aug 2		1:00A M
	Examir		4a. Facility Name (If not institution, give			City, Town, or Location of Dea	ath	4c. County of Dea	
			St. Vincent DeP			Frostburg		Allega	
	Funeral		5. Social Security Number 6. Set 1215-80-6926	7. Age (In yrs. las		nder 1 Year   If Under 24 Hi hths Days Hours Mi	n. (Month, Day, 1		thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	31			Aug 23,	1913 Mai	ryland
	yland		10a. State 10b. County		Town or Location				10d. Inside City Limits
	a-1s	ctor	Maryland Allegar	ıy Fr	ostbur	3			ty∰Yes 2 No
	ith the or 28	Director	10e. Street and Number			Zip Code	10	g. Citizen of What Co	ountry?
	rs after death with the Maryland ', or Items 23a or 28a-1 show saminer must be notified at		261 E. Main St			21532		USA	
	er de	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
0000	ours after rel', or ite Examine	by F	1 ☐ Never Married 2 ☐ Married 32 Widowed 4 ☐ Divorced	1	1 🗆 Y	es 2 No Specify:		Specify: V	White
	프 크림		15. Decedent's Edu		16a. Decedent's	Usual Occupation	10	6b. Kind of Business	/Industry
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y Id	ould Men Parke	၉	Robert Benedict				es Trimb		T. 0. (1)
Z	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Ty			dress (Street and Number or I		•	
บ้	Healt Healt tem 2		Patricia Filsing	20b. Plac	ce of Disposition	(Name of		DUTG, MD Dc. Location - City or	
2	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	netery, crematory	, , ,	Aug	n:	D3 15401
pairimor	E 0 3		21. Signature of Funeral Service Licens			rematory 30 , and Address of Facility	,2004 0	IIIOIICOWI	n, PA 15401
ğ	Depart Import any in		male	Sthe a.	) Haf	er Funeral	Service,	PA	
			23a. Part 1. Enter the dishase, in compliance, or heart failure. List only of	ications that caused hardeath.	Do not enter the	mode of dying, such as cardi	ac or respiratory arres	ale, MB	21502 Approximate Interval Between
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POX	andin use	Z	23b. was decedent pregnant	23c. If yes, outcome of pregnand 1□Live birth 2□Fetel d		pic pregnancy		23d. Date of de	,
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ě	has l	Ig III					24a. Was an autopsy performe	l prior to	utopsy findings available completion of cause of
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DIVISION OF	er death rector: by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fa	ctory, office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
5	itel or rel Di								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio	ledge, death occu on and/or investig	rred at the time, date and pla ation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		29c. License number	290	d. Date signed (Mont	th, Day, Year)
	F 3 F 8		5	Loanolling N		D144 E	34	-	
			30. Name and address of person who co		23a) (Type, Print)				
			Dr. S.L. Sand	nir 48 Ta	urn to	errace f	rostburg	MD	21532
	Sta		31. Date filed (Month, Day, Year)	7 2004 Signatu	ire A	hack s		)	
	Regist	131	JEL A	I LOUTP MAKEN		0			

			State of Maryland / Department of Health and Mental Hygiene  1- State   Certificate of Death   Reg. No.									20170		
4	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  2. Date								ath	Voor	3. Time of Death	
			A1frod T Torrows 1/ 200/									12:22 A M		
	Examin		4a. Facility Name (If not institution	n, give street and nu	ımbər)		4b. City, Town,	or Location	n of Death	1.7	4c. County o	f Death		
			Forest Glen N						Sprin			tgon		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last				Months Days Hours Min.				8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)  9. South Carolina			
			237-34-5268 Usual Residence of Decedent		80		L			Nov. $2/$	1923 IS	outh	∟Carolina_	
yland	naturel', or Items 23a or 28e-f show disal Examiner must be notified at		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li									0d. Inside City Limits		
e Mai		ctor	DC					ingto	n			1 ∑Yes 2 □ No		
it th		Directo	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
ath w		la l	1418 Sheridan St., N.W.			20011							States	
ar de		Funeral	11. Marital Status	Amed Forces?			<ol> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>					No- 14. Race - American Indian, Black, White, etc.		
S aft	P	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	If the Ci	2 ∐ No		1 □ Yes 2 🙀 No	Specif	y:		Specify:	В1	ack	
5-UU36 72 hours af	Health and Mental Hygiene. em 27 is marked other than " ther traumatic event, the We		15. Decedent's Education				16a. Decedent's Usual Occupation					16b. Kind of Business/Industry		
		ompleted	(Specify only higher Elementary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)					,				
d within		E	Elementary/Secondary (0-12) College (2-4or 5+)				OIC Te			Private				
<b>D (a)</b>		Be C	17. Father's Name (First, Middle,					18. Mot	her's Name		Maiden Sumame,			
/lan		2	O.B. Gilliam Do							Doroth	rotha Jowers			
<b>Mar</b> d 2 sho			19a. Informant's Name/Relations								er, City or Town, S		Code)	
1 and			Alberta Pryo	r - Siste			The second second			-	., DC 20			
			20a. Method of Disposition 1	3 □Removal from	State 20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pl	асе)	D	ate	20c. Location - C	ity or To	wn, State	
E a			° 4 ☐ Donation 5 ☐ Other (S	pecify)	1		k Cemet		8/20	/2004	Wash	., D	C	
Sal			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home											
<b>-</b> a			John I.	Herra	U III	2					Wash.,	DC 2		
Ph	ysician		23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.											
	physician and strength was the burial-transit		resulting in death)  Ne to (or as a consequence of):											
L			Sequentially list conditions, b									4.		
pe		ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
ou, be executed		xan												
ate be e	sician	dical												
X 687	phy:	edic												
	nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan						23d. Date	Date of delivery		
death	as been signed by the attending p 2 should be detached for use as	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregi	birth 2 ☐ Fetal on the properties of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealers of dealer		]Ectopic pregnand ] Other (specify) _	су			Month Day			
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ecords, P.O. Bo law requires that the death		by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did to	23e. Did tobacco use contribute to the cause of death?			
COLD:			* Unelle Co							1 U Y	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
law re		plet	Ceretre	Vasuell	s acc	de	UP .			24a. Was				
r g	ate h	Completed	Queletes mellike							perfo	performed? death?			
VICION: T	within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Be (	25. Was case referred to medical examiner?  26. Place of Death (Check only one)											
OI V		2	examiner   1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nure: Home 5   Residence 6   Other (Specify)										)	
ng P		 	27. Manner of Cath 1 Autural 5 Pending 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?											
VISION Attending		cati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural R											
or At	oliter of pirec in by	ertification;	4 Homicide determ	inod 288. Place	e of Injury - At hon ling, etc. (Specify)	ne, tarm, str	eet, factory, office		2	City or Tow	otreet and Number vn, State)	or Hurai	Houte Number,	
plter	erel C	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Hos	24 hc Fun etely i	edical		Exeminer: On the b										
o the	omple	Mec	29b. Signature and title of certifie		7		29c. Licen	ise number	. ,		29d. Date signed	Month, L	Day, Year)	
-	S ► 0		Minon	1. Sen	ikia.	M20	000	167	4		2/19/2	00	4	
06	1		30. Name and address of person	who completed cau	se of death (Item:	23a) (Type	Print) 23	09	SHO	REF	tezb z	20	r	
U	- (5)		MYRON L. LENKIN MD WHEATON MD 20902											
	Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Signatu	-			<del>-</del>					
Registrar AUG 2 4 2004 Registrar														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** George Valentine Johnson, August 18, 2004 3:55 p^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Dey, Yeer) Feb. 14, 1919 Michigan If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□F Days Hours 429-09-0048 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7015 Varnum Street 20784 U.S.A. Itama 23a Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: if them 27 is marked other then *naturel', or Itama 23.
ury or other fraumatic event, I.m. Medical Evantue must by Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Foreman 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hilja Tuulas Frank Evarts Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurene K. Johnson - Wife 7015 Varnum Street, Landover Hills, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State

Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or once. MD Veteran's Cemetery Aug. 23, 2004 Cheltenham, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signal re of Juneral Service Licens 4739 Baltimore Avenue, Hyattsville, MD 20781 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** sepsis Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIALYSIS Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Stage Renal Discuse I or Attending Physician: The law requires that the death certificate be executed tire death.

Director: After this certificate has been signed by the ettending physician and in by the Unreal director, page 2 should be deached for use as the burial-transit in by the Unreal director, page 2 should be deached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Discare 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Falhere 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manufer of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funerel D Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sridhar Chatrathi, M.D. 8100 Good Luck Road #302, Lanham, MD 20706

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2004

Registrar's Signature

Physiciar /Medica		1. Decedent's Name (First, Middle, Last) CHARLES JEFFERS	artment of Health and intricate of Death	2. Date of Death Month		3. Time of Death
	al -	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		28, 2004 4c. County of Deat	0813 P. M
Examine	1	Washington Adventist Hospital	TAKOMA Park		Montgomer	
Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex  1 MM 2 F  48 Yrs.		8. Date of Birth		hplace (State or Foreig untry)
* -	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limit
if she	ក្ត	Md. Prince Georges Lewisd				1 √ Yes 2 □ N
or 28;	Funeral Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Co	untry?
nust	era	2506 Chapman Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was December of Hispania Origin? (6		U. S. A.	roop Indian
100	2	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give A Year or Dates:	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	to Rican, etc.)	Black, White	e, etc.
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d ta		17. Father's Name (First, Middle, Last) Charles Jefferson, Sr.		me (First, Middle, Ma tine Watk		
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nent of Health a int: If Itam 27 Ia iry or other trai		20a. Method of Disposition  20b. Place of Disposition  1 ☐ Wigurial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of	Date 20	Suitland,	Fown, State
Department of Bimportant: If Its any injury or of once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility W 3447 14th St., N.	. H. Bacor W. Washing	Funeral ton, D.C.	Home, Inc. 20010
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ld be	י ע			24a. Was an autopsy periorme	prior to co	opsy findings available ompletion of cause of
				1 X Yes 2		
	מ	25. Was case referred to medical examiner?  Hospital:   Impaging to 2 TED/Outpatient   1 Temperature   1 Tempe		ath (Check only one)	C [] ()	
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Joshua 04-056 RJ	Andrew 30	γK	Unpend item	se Type or Prii 23a, 27, 28a State of M				II Copies A	Are Legible	э.
110			1 State Registrar		Ce	ertificate of	Death		eg. No.	28183
	Physici /Medic		Decedent's Name (First, Middle JOSHUA ANDRE	W KIGHT				2. Date of Death August 3	30, Day 2004 Ye	3. Time of Death 09:05 P _M
	Examir	ner	4a. Facility Name (If not institution				or Location of Death		4c. County of D	Death Dery County
2	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda)	Gaithers  O If Under 1 Year  Months Days	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
25	Director		216-08-4971  Usual Residence of Decedent	1 <b>X</b> M 2□F	34 Yrs.	I VIOTATIS Days	riours wiiri.	8. Date of Birth (Month, Day, MAY 10	1970	MD
	iryland ihow		10a. State 10b. County	GOVERNY.	10c. City, Town or I					10d. Inside City Limits
	the Ma	ecto	MD MONT  10e. Street and Number	GOMERY	NORTH I	,				1 ☐ Yes 2 No
	deeth with the Maryland ims 23a or 28e-f show finant be netition at	ai Dir	12400 ROUSSE	AU TERRACE	E	10f. Zip Code 2087	8	10	ng. Citizen of Wha US.	
980	s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examiner must be refilled at	by Funeral Director	11. Marital Status  1  Never Married 2  Marri 3  Widowed 4  Divorced	12. Was Decedent Armed Forces?  1  Yes 2 1 Yes, Give Year or Dates:		. Was Decedent of it Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. WHITE
5-0	72 ho "natur	eted	15. Decedent (Specify only highes		(Giv	edent's Usual Occupe kind of work done	during most of work	ina 1	16b. Kind of Busine	ess/Industry
21215-0036	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	ife.	DO NOT use retire	ed)		HOME TW	
<u> </u>	al Hyg d other	Be C	17. Father's Name (First, Middle, I	,	Crit	TENTER	18. Mother's Name	e (First, Middle, M	faiden Sumame)	PROVEMENT
Maryland	d Meni d marke marke	2	RAYMOND M. K  19a. Informant's Name/Relationsh		10h Mai	line Address (Otto-		T. DEN		
Ma	alth an 27 is i		RAYMOND KIGH	T / FATHER			t and Number or Rura <b>EAU TE</b> RR			e, Zip Code) , MD 20878
Baltimore,	permit. Pages 1 and 2 Department of Health al Importent: If Item 27 is any injury or other treu		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)	Date 2	0c. Location - City	
ltim	artmen artmen ortent: injury		'4 □ Donation 5 □ Other (Sp 21. Signature of uneral Service)	pecify)		CK CREMA  22. Name and Addre	AT. 9/1/	04 F	REDERIC	CK, MD
B	Depar Impo any ir	(). ·	· W	M		HILTON 1	FUNERAL X 86, BA	HOME	TE MD	20838
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do not er	nter the mode of dyi	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
	Pnysician /Medical	f j	Immediate Cause (Final disease or condition resulting in death)		Lc (heroin a consequence of):	) intoxic	ation			Onset and Death
	Examiner		Sequentially list conditions	b	a consequence on.					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
ó	oe executed cien and urial-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
876	ate be	dicai		d						
P.O. Box 6876	or Attending Physician: The law requires that the death certificate be executed infer death. Interdeath. After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	deliver
. B	ed for	siciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		□Ectopic pregnancy □ Other (s <i>pecify</i> ) _	у		Month	Day Year
P.O.	that the de led by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant condition		ut not resulting in the	inderwing cause an	ven in Part I	23a Did toba	acco use contribut	to the cause of death?
Division of Vital Records,	quires in signe uld be				The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	and onlying datase giv	TOTAL TALL TO			Probably 4 Unknown
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a R	ilclan: The l certificate ha rector, page ;							▶ performe	ed? death ∃No 1.74Y	?
. Vit	iding Physician: th. : After this certifica ? funeral director, i	To Be	25. Was case referred to medical examiner?  1	Hospital:	nt 2 ER/Outpatie	nt 3 DOA Oth	26. Place of Death			pecify) At scene
0 1	Ing Ph		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury		rv at	28d. Describe how	v injury occurred	AL SCENE
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	To the Hospitel of within 24 hours of To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of examiner: On the basis of and manner sta	examination and/or in	th occurred at the tin exestigation, in my o	me, date and place, a ppinion, death occurre	and due to the cau	ica(c) and mannar	ac ctated
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		-	Ulorke	M)						
			30. Name and address of person w	the completed cause of de	eath (Item 23a) (Type	11 Penn S	Street, Ba	ltimore,	Marylan	d 21201
	Stat		31. Date filed (Month, Day, Year)		ur's Signature	1				
	Registra	ar	SEP 0	7 2004	en &	appear				

			1 - For State Registrar	State of Maryla	•	artment of H tificate of I			ene g. No 2004	28186
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	LANGE	NSTEI	N		2. Date of Death Month AVG V5	Day, Year	3. Time of Death
<b>3</b>	Examin Funeral Director		4e. Fecility Name (If not institution, live s 919 Concord Stree 5. Social Security Number 6. Sex 212-24-5773	et	rs. last birthday) 81\rs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 4	Year) 9. Bir	on County thplece (State or Foreign ounty) ryland
	aryland show dat	_	Usuel Residence of Decedent  10a. State 10b. County	1	City, Town or Lo					10d. Inside City Limits 1  Yes 2 □ No
	vith the Mi	Director	Maryland Washingt	on	Hagerst	10f. Zip Code		10	g. Citizen of What C	1
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depcimient of Healih and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Exeminar must be notified at once.	by Funeral	919 Concord St.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	40 ispanic Origin? (Spin, Mexican, Puerto  Specify:	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ame Black, Whi Specify: WI	
21215-0036	J within 72 hou jiene. r than "natura the Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	lent's Usual Occup kind of work done of DO NOT use retired	ation during most of work ()	ing	6b. Kind of Business Personal 3	
Maryland 2	should be filed nd Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Silas Smith		Tious	CWITC	18. Mother's Name			NESTUCIOE
e, Mar	1 and 2 sho Health and Im 27 is m	0	19a. Informant's Name/Relationship (Typ.  Joseph Kerr Langer)  20a. Method of Disposition	stein		Concord	Street Ha	gerstown	City or Town, State, .  Maryland Oc. Location - City or	1 21740
Baltimore,	int. Pages entment of the containt: If its injury or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the containts or of the contai		1	emoval from State	cemetery, crem Smithsbu	natory or other place ing Cemete	ery   Aug.	24,04		g, Maryland
es E	Department of the services once		23a. Pert1. Exter the disease, or complice shock, or heart failure. List only on	cations that caused the d	13	31 Easte:	rn Blvd.	N. Hager	stown, Man	cyland 21742  Approximate Interval Between
I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CONGES	equence of):		^			Onsel and Death UEANCS
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68760,	ficate be executed physicien and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cons DENTE	sequence of):					MUNITES
P.O. Box 6	The law requires that the death certif te has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of prediction of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the se	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	yibuting to death but not in	resulting in the un	derlying cause give	en in Part I.		acco use contribute lo	o the cause of death? robably 4 DUnknown
Division of Vital Records,	ilcien: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy perform	ed? prior to death?  No 1 □ Yes	utopsy findings available completion of cause of
of Vi	d is	To B	examiner? 1 ☐ Yes 2 ②No H	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,		3□ DOA Othe 28c. Injury Work	4   Nursing Ho		ce 6 □Other (Spe	city)
Division	in State	ertification;	1	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	M 1□'	Yes 2 □No	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one) Medical Examin	ician: To the best of my left: On the basis of exam and manner stated.	knowledge, death ination and/or inv	estigation, in my of	oinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Thayer Anne Larrimore 11:30 PM 17 2004 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab. Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days 1□M XXF 219-03-6673 83 Yrs Director Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ret", or Items 23e or 28a-f show Examiner must be notified ut Be Completed by Funeral Director Maryland Anne Arundel 1 ☐ Yes 2 No Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "neturet", or Items 23e or? 1557 Widows Mite Road 21037 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No White Specify: 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk State of Maryland of Health and Mental Hygie fitem 27 is marked other r other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Blay Elizabeth Martin ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter G. Larrimore, Jr./son 1557 Widows Mite Road Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent: If it any injury or o once. Burial 2 Cremation 3 Removal from State Larrimore family cem. 8/21/2004 Edgewater, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signatura di aneral flervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Physician Pulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Antery disease Insulin - dependent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 2 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) amstron, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sland Road Amapolis, mp 21401 139 old Sol omons AUG 1 31. Date filed (Month, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month Latimer Steven 8:31A.M 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5804 King Glenn Daile MD
If Under 1 Year If Under 24 Hrs. Arthur Way Prince Georges 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 213-56-8954 1∑M 2□F 54 Yrs. Director 1, 1949 Washington, DC Usual Residence of Decedent with the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits irel', or items 23a or 28e-f show Prince Georges FlennDale Completed by Funeral Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 King Arthur Way U.S. A. 20769 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 ☐ Widowed 4 ☐ Divorced treumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst Priamerica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sprague J. D. Latimer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5804 King Arthur Way, Glenn Dale, Maryland 20769 19a. Informant's Name/Relationship (Type, Print) Robin Latimer/ Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Ft. Lincoln Cemetery 8/23/2004 Brentwood, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure resulting in death) /Medical Due to (or as a consequence of): Examiner Colistantana Miltiforne Brain Tunar Sequentially list conditions, and had a scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending death. after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel [ is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00055229 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dept. Neurlogy Enc M. Aldrich John Hopking Horpins 600 N. Wolf St. Bult. MD 21287 ar's Signature 32. Regis 31. Date filed (Month, Day, Year) State 2004 Registrar

			For State Registrar	State	of Marylar		artment of F		nd Mental Hy	_	1979		
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lan)			19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number	or Rural Route Numb	er, City or	r Town, State,	Zip Code)	
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			Registrar  1. Decedent's Name (First, Middle, Las	, ,				2. Date of Death		3. Time of Death
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	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Lo	cation				10d. Inside City Limits
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336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show hy injury or other traumatic event, ite Modical Examinating must be intillified at ODE.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2√☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, White Specify: B]	e, etc.
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of Vital	> 07 TJ	To Be	examiner?	Hospital: 1 ☐ Inpatient 2.☐ ER	VOutpatier	nt 3 DOA Othe	-	th <i>(Check only one</i> ome 5 ☐ Reside	nce 6 Other (Spec	erfy)
o u	ng fter ine	lon: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	Bb. Time o	f 28c. Injury Work	at ?	28d. Describe ho		
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		e, farm, sti		′es 2 □ No	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	Hospite 24 hours Funerei	dical C		ysician: To the best of my knowle iner: On the basis of examination and manner stated.						
	To the within To the comple	Me				29c. License	number	29	d. Date signed (Month	, Day, Year)
			> Spupta	MD		D00	53150	P	106057 2	15 2004
			30. Name and address of person who	completed cause of death (Item 2)	3a) (Type,	Print) G BACU 2	WEL NE	cu RD	BALTIMONE	15515CM
ı	Sta Regist		30. Name and address of person who SHAWNIMALA (and 31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e s	book				

			1 - For Stete Registrar	State o	f Marylar		artment of		nd Mental I	Hygien	· * * 1	20100
			Decedent's Name (First, Middle, L.	ast)					2. Date of	Death		3. Time of Death
	Physici /Medio		Rosa Y. Lawr	ence					Month Augi	ust 20	, 2002	8:48 p M
	Examir		4a. Fecility Name (If not institution, g	ive street and nu	m <i>ber</i> )		4b. City, Town	or Location of D			. County of D	
			Shady Grove Adve				Rockvi			1	Montgon	nery
l	Funeral Director		215-38-2588	Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of (Month, July)	Day Year		Birthplace (State or Foreign Country) Orgia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary f sho	ρ	Maryland Montgom	erv		ithersb						1 X Yes 2 No
	r 28a	Director	10e. Street and Number		das	chersb	10f. Zip Code			10a. Ci	tizen of What	Country?
	th with		445 Lynette Stre	et			20878			U. S	S.A.	,
စ	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other then "naturel" or Items 23a or 28a-f show event, the Mydical Exempre must be neithed at	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Fo	2 No				? (Specify Yes or Puerto Rican, etc.)			merican Indian, hite, etc.
21215-0036	hours a	ed by	3 🕅 Widowed 4 □ Divorced	If Yes, Gr Year or D			1 ☐ Yes 2 ☒ N			101	Specify: V	
715	nn 72 n "na	Completed	(Specify only highest g	rade completed)		(Give	dent's Usual Occ kind of work don DO NOT use retii	e during most of	f working	16b. K	(ind of Busine	ss/Industry
212	d with giene ar the	mo	Elementary/Secondary (0-12)	College ( 5+			tor: Pri		Teacher	Educ	cation	
	should be filed withir or Mental Hygiene. marked other then matic event, ILEM.	Be	17. Father's Name (First, Middle, Las	et)				18. Mother's	Name (First, Mid			
<u>yla</u>	ould by Ment arked	Tol	James M. Youngblo	ood				Ada Ba	ugh			
Maryland	2 short and land	İ	19a. Informant's Name/Relationship						or Rural Route Nu			
	1 and 2 Health a sm 27 I		Hiram L. Lawrence	e, Jr			ynette S sition (Name of	street,	Gaithers			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic ex		1 🖾 Burial 2 ☐ Cremation 3 l  '4 ☐ Donation 5 ☐ Other (Spec		State	cemetery, cren	natory or other pi Memoria	, µ,,,,,,	ust 25, 20 is	04		or Town, State Maryland
Balt	permit. Departimport Import any inj		21. Signature of Funeral Service Lice	ensee 2 A a a A	Lann	22 Amai	Name and Add	ress of Facility	Gasch's	Funer	al Hom	e, P.A. , MD 20781
	-11		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that o	aused the deat							Approximate
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. as	oirati		neum	onia				Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	or as a conseq							
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
58760,	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last	Due to	or as a conseq	uence of);						
_				O								
P.O. Box	The law requires that the death certific site has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 27 No 9 ☐ Unknown	1□Live b	come of pregna irth 2 Feta ant at time of d	Ideath 3	Ectopic pregnan Other (specify)	су			23d. Date of d Month	lelivery Day Year
	that the ded by	/ Ph	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	derlying cause g	iven in Part I.	23e. Di	id tobacco u	use contribute	to the cause of death?
spic	w requires been sign should be	ted by									1	Probably 4 □Unknown
Records,	he law re has be ge 2 sh	Completed								tas an atopsy arformed?	24b. Were a	autopsy findings available completion of cause of
a		e C	25. Was case referred to medical						1□ Yes	s 2 No		es 2 No
>	ysicie s cert direct	OB	examiner?	Hospital:	npatient 2	EB/Outpatient	1 3□ DOA O	the man	Death (Check onling Home 5 🗆 Re	2.5	6 Dotter (6-	
on of	or Attending Physicien: The lav ifter death. Director: After this certificate has in by the funeral director, page 2	tlon: T	27. Manner of Death Natural 5 Pending	28a. Date (Mont		28b. Time of Injury	28c. Inju		28d. Describ			өсігу)
Division of Vital	of or Attendated after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place	of Injury · At hong, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or	n (Street an Town, State	d Number or I	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one)  Certifying P  2 Medicel Exe	hysicien: To the miner: On the ba and mann	asis of examina	wledge, death tion and/or inv	occurred at the testigation, in my	ime, date and pl opinion, death o	lace, and due to the courred at the time	ne cause(s) e, date and	and manner a	as stated. ue to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier  ———————————————————————————————————	J.M	stry	MO		se number		1 -		nth, Day, Year) O, 2004
	e (15)		30 Name and address of person who Alicia Mishy	completed caus	e of death (Item	123a) (Type, F	Print) wher D	rive	Rockvi			
	Sta	-	31. Date filed (Month, Day, Year)	₫ 32. R	egistrar's Signa	ture						
DH	Registra MH 17 Rev 1/20	1.0	AUG 2 4 2004	Bleed	· K	port	,					

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

KUSSE// 31. Date filed (Month, Day, Year) AUG 172

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

29c. License number

555 Cynwood

29d. Date signed (Month, Day, Year)

8/16/2004

EASTON, MD 21601

DR.

			For State	State of Ma	aryland	_	artment of I				giene Reg. No.	001	2010	
	Physicia	an	1. Decedent's Name (First, Middle, L	.ast)		1	prell	Dean		P. Date of Dea Month	ith Day	Year	3. Time of Dea	
	/Medic	al	4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town,	or Location		August		2004 County of Death	12:48	AM
	Examin	er	1103 South Schum		#9		Salisbu				W	icomico		
	Funeral Director					ast birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birtl (Month, Day July 31,	, Year)	9. Birth Con 7 Oh	nplace (State or Fo untry) 10	reign
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation						10d. Inside City Li	mits
	Maryla a-f sho	tor	Maryland Wicom	ico	Sa.	lisbur	V						1 XYes 2	] No
	ith the or 282	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Co	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "natural", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Evantment must be motified at ance.	Funeral	11.03 South Schum  11. Marital Status  1 Never Married 2 Married	12. Was Decedent I	Ever in U.S	s. 13. Y	21804 Was Decedent of f Yes, specify Cub		rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		USA 14. Race - Amer Black, White		
036	ours after	by	3 Widowed 4 Divorced	1 1 1 Yes 2 1 h If Yes, Give Year or Dates:			1 ☐ Yes 2🌠 No	Specify	y:			Specify: W	nite	
Maryland 21215-0036	in 72 ho "natu "edical	Completed	15. Decedent's (Specify only highest s	grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mo	st of working	,	16b. Ki	nd of Business/I	ndustry	
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	and 2 Balth a n 27 le		Joan Lavell	(wife)	1		outh Schur	aker D			_			
altimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3		Ce	emetery, crei	sition (Name of matory or other place)  eek Ceme		Da			cation - City or '	own, State	
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8760,	cate be executed oblysician and the burial-transit			d										
Box 6	as as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pregnanc	234			2	23d. Date of deli	•	
P.O. B	that the death cer ed by the attendir detached for use	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at			Other (specify)	- ,				Month	Day Year	
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9			30. Name and address of person w					Chac	ot Ca	1 i ab		المراجعة	21004	
Y	Sta	ate	John P. Hakim, I	M.D. I.	rar's Signal	ture /	Division		et, Sa	ıısour	<del>Y</del> + -1√	aryıand	21804	
	Regist	rar	AUG 17	2004   24	wa	$\mathcal{L}^{\mathcal{G}}$	Soon	6/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 11CHAS **Physician** 10:56 AM 6 /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner hestertown GAGH KIVER ster If Under 1 Year | If Under 24 Hrs. 8. Oate of Birth (Month, Day, Yea April 11, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Year) 1933 Washington, DC 576-54-8232 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7337 Wilkins Lane 21620 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert C. Lieber Isabel Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Guy Michael/husband 7337 Wilkins Lane, Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot ☐Burial 2 Cremation 3 ☐Removal from State Chesapeake Cremation 08/19/2004 Stevensville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows Helfenbein & Newnam Funeral Home, P.A. uk 130 Speer Road, Chestertown, MD 21620 ens that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition **Physician** & ru with resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and use as the burial-tran The law requires that the death certificate be execu Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 20 No 1□ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D17036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are Chartentom mel. 20120 Woshington Ross Juson K. 516 mo 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

# 200-54-4400 Mongary Barbara ANN
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mongan Barbara /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Western Maryland Hospital Center Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 6,1948 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 💢 F 56 220-54-4400 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD Washington Hagerstown Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21742 U.S.A. 1500 Pennsylvania Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Seamstress Shoe Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Merle Boward Anna (Unknown) Boward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I Kirk C. Downey/P.R. 92 W. Washington St. Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
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once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 8/26/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPATIC **Physician** disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the buriat-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 22,80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Hagerstown, Md 21742 Ghazalla Qadir, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's Signature

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Vital Records, P.O. Box 68 sician: The law requires that the death certifica	has been je 2 shoul	Completed	æg	rertens enerali	re .	arch	utes			Was an autopsy	prior to	utopsy findings available completion of cause of
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	Regist	rar	AUG 26	2004	eun .	B. A	serle					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 10.08 Argust 20 2004 Paschal Augustus Marketti /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia 8. Date of Birth (Month, Day, Year)

July 8 1916 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** MM 2□F Months Days Hours Min. Director 193-05-5994 88 PA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or items 23e or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Carroll Westminster Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 London Court 21157 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ©©∜es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Specify: 3√2 Widowed 4 □ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter R Bethlehem Steel Co Pages 1 and 2 should be filed a nent of Health and Mental Hygic out: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maria Archie Joseph Marketti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. Elaine Marketti/daughter 420 London Court Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 1 Surial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 8/23/2004 Dundalk, MD 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 23a. Part. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK SEOTIC Physician /Medical ras a consequence of):
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Natar Nevel Disease. Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and -transit The law requires that the death certificate be executed burial-t P.O. Box 68760. physician Completed by Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ■Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifig 29c. License number 30641 30. Name and address of person who completed caute of death (Item 23a) (Type, Print)

Raumed Sahapa M 201-109 Back River Neck Road MD 201-109 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2004 Kleen & Spark Registrar

			1 - For State Registrar	State of	Marylan		artment of I		and M	lental		ene	04	28196
			Decedent's Name (First, Middle, La	st)						2. Date	of Death	)	-	3. Time of Death
	Physici /Medi		Margaret A. Malo	ney						Aug	ùst	2 ³ , 2	$00^{4}$ ar	0943 А м
	Examir		4a. Facility Name (If not institution, giv		•		4b. City, Town, o		f Death				ty of Death	
		П	Southern Maryland				Clir		0444			Pri		eorge's
	Funeral Director		180-10-/16/	iex /. □ M <b>¾</b> □ F /.	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date ( (Mont Nov .	h. Dav.	1915	Coul	place (State or Foreign htry) Sylvania
	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
	Man,	tor	Pennsylvania Del	aware		Linwood	4							1 ☐ Yes 2X No
	th the	Jirec	10e. Street and Number			LIIIWOO	10f. Zip Code				10	g. Citizen o	f What Cour	ntry?
	23a	Funeral Director	123 Harvey Avenue				19061					U:	S	
	er de	nne	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13. \	Was Decedent of H f Yes, specify Cub	dispanic Orig an, Mexican	gin? (Spe , Puerto	ecity Yes o	or No-	14. Ra	ace - Americack, White,	an Indian, etc
36	ours after death with the Marylan raf', or Items 23a or 28e-f show Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	_		I ☐ Yes 2█ No	Specify:					ity: Whi	
9	72 hours after death with the Maryland netural', or Items 23a or 28e-f show dreal Exempler must be multified at	ted	15. Decedent's Ed	ducation		16a. Deced	tent's Usual Occup	ation			1	6b. Kind of	Rusiness/In	dustry
215	hin 7:	plet	(Specify only highest gra	de completed) College (1-4)	or 5+)	(Give	kind of work done OO NOT use retire	during most	of worki	ng		ob. Italia of	Dusinessin	dustry
21	filed within Hygiene. Ither than "	Completed	12	- College (1 +		Manag	er			_		C1c	othier	•
Maryland 21215-0036	0 = 0 \$	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, M	iddle, Ma	aiden Suma	vme)	
yla	should be nd Mental marked o matic eve	Ţ	Jenkin Jones							h Wi				
Mai	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (				g Address (Street						n, State, Zip	Code)
9	1 an Heal tem 2		Carole Lee - Daugh 20a. Method of Disposition	iter	20b. P	lace of Dispo.	Lisa Dri sition (Name of			rt, r			- City or To	wn State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumstic e pages.		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		ıte Imn	emetery_cren naculat	te Heart	ce)		0-04	U	pper	Chiche	ester
atti	mit. F partm porter r injur		21. Signature of Funeral Service Licer		153	Mary (	Cemetery Name and A dre Intt Fune	ss of Facility		0 0 1	10	wnsni	p, Per	nnsylvania
ä	permi Depa Impo any in		Mark M. Bu	Than you	)	Р.	o. Box	156,	ome Wald	orf.	MD	20604		
			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	hund	PASIV	e other	roscler	tic C	ad	insa	501	local	SPACE	Onset and Death
	/Medical Examiner		resulting in death)	Out to (or	as a consequ		1000191	21/01	MU	1040		Clay (1)	عدالا	
H		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to /or	as a consequ	uongo of\s								
	ted nsit	nine	cause. (Disease or injury that initiated events	Due 10 (01	as a consequ	derice or).								
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):								
58760,	icate be executed physician and s the burial-transit	dlcal	(	d										
_	- m	w	IF FEMALE:											
Box	death certif e attending id for use a	Physician/M	23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	ne of pregna 2  Fetal		Ectopic pregnancy	,					ate of delive	
0.	0 0	/slcl	in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	4□Pregnant 9□Unknowr			Other (specify)				_	М	onth	Day Year
<u>α</u>	requires that the een signed by th nould be detache		Part II. Other significant conditions c	ontributing to deat	n but not resu	ulting in the un	deriving cause giv	en in Part I		230 (	Oid toba	cco use con	tribute to th	e cause of death?
Vital Records,	uires tha signed Id be del	d by	asthne	3			and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	orr in a care i.				2 🗆 No	3 ☐ Proba	17
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Be	о <u>с</u> <u>е</u>	Completed								a	utopsy	ig?	prior to con death?	psy findings available appletion of cause of
ital		a	25. Was case referred to medical					26. Place	of Death	(Check o		No	1 🗌 Yes	2 No
	ys dis	ToB	examiner? 1X∑ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	atient 2🔼	ER/Outpatient	3□ DOA Oth				-	e 6 Ott	ner (Specify	)
n of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of II	njury Da <i>y Year)</i>	28b. Time of Injury	28c. Injun	/ at	_			injury occur		
sio	Attending r death. sctor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ N	0					
Division		Certification:	4 Homicide determined	286. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, office		2	8f. Location City or	on (Stree Town, S	et and Numi State)	ber or Rural	Route Number,
	a Hospitel or Atten 24 hours after deatl 5 Funerel Director: etely filled in by the		29a. Certifier 1 Certifying Ph	vsicien: To the be	st of my know	wledge death	occurred at the time	o data and	ninna n	ad due te	the entire	(-)		
	To the Hospitel or within 24 hours after the Funerel Dir completely filled in	Medical	(Check only one) Medical Exam	niner: On the basis and manner	ot examinat	ion and/or inv	estigation, in my of	pinion, death	occurre	d at the ti	ne, date	and place,	anner as sta and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		0/	) <u>o</u> .	29c. License	number			29d	. Date signe	ed (Month, E	Day, Year)
			tatrul	ron ica	tall	) luas	0.0	C.M.E.			A	ugust	24, 3	2004
	Λ		30 Name and address of person who	completed cause of	death (Item	23a) (Type, F	Print)		D 7.				. 3 . 2 2 2	201
M	Y 10		MARICIA ACA	710V- L	SILAK	M111	Penn Sti	reet,	Balt	TWOIL	e, M	aryla	na 21.	ZUT
	Sta Registra	_	31. Date filed (Month Alay Gen) 6	2004 32. R. II	strar's Signat	ure A	Garage							
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	-		1 - For State Registrar  1. Decedent's Name (First, Middle		Marylar		artmen rtificat		ealth and N Death		Reg. No.	1000	28	97
п	Physici			_		M: 221 -	<b>.</b>			Month	Day			of Death
	/Medio		Shirley 4a. Facility Name (If not institution	Ann		Middle		Town or	Location of Death	August		2004 County of Deal	6:24	Р м
	Examir	lei •	3248 Ryon Cour		00.7		1	dorf				Charles	п	
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			holace (State	or Foreian
	Director		224-80-4472	1□M 2 <b>X</b> F	52	Yrs.	Months	Days	Hours Min.	(Month, Da			hplace (State untry) vland	or v or origin
	D .		Usual Residence of Decedent						123091	100 071.		TRAL.	yaana	
	anyla shov	2	10a. State 10b. County			ty, Town or Lo	ocation						10d. Inside	
	he M	Directo	Maryland Charles	5	Wa	ldorf								s 2 No
	hours after death with the Maryland lurel', or items 23a or 28e-f show all Ever if we profit at		10e. Street and Number				10f. Zip					zen of What Co	untry?	
	eath	Funeral	3248 Ryon Court	12. Was Deced	ant Ever in I	16 42		601	1.011040	7 11	USA			
	iter d	'n	17. Marital Status  17. Never Married 2 ☐ Marri	Armed Ford	es?	1.5.	was Deced If Yes, spec	ent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No Rican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>		
936	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Dat	es:		1 ☐ Yes	2[ <b>X</b> No	Specify:			Specify: B	Lack	
Ö	C/ 65 C/A	ted	15. Decedent			16a. Dece	dent's Usua	I Occupa	ıtion		16b. Kii	nd of Business/	industry	
215	d within 7 jene. r than "n ILe Medi	ple	(Specify only highes Elementary/Secondary (0-12)	College (1~	4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired,	luring most of work )	ing			,	
21	filed wi Hygien other th	Completed	12		,	Bus D	river				Ke]	ller		
nd	be filed tal Hygid d other svent.	Be	17. Father's Name (First, Middle, L						18. Mother's Name	e (First, Middle,	Maiden	Sumame)		
<u>×</u>	2 should be and Mental is marked ceumatic sv	2	Joseph B. Middl						Mary C.					
Maryland 21215-0036	ges 1 and 2 should be filed it of Health and Mental Hyg If item 27 is marked othe or other treumatic svent,		19a. Informant's Name/Relationsh						nd Number or Rur					
e)	1 and Health sm 27 ther tr		Sharon Gray/ Da  20a. Method of Disposition	aughter	20h [				Oak Dr Wa		_			
Baltimore,	or of		1 ⊠Burial 2 ☐ Cremation	3 Removal from Si	410	Place of Dispo cemetery, cren			9)	Date		cation · City or		
睛	rtmer rtent rtent njury		' 4 □Donation 5 □Other (Sp	•	St	. Mary			8/30	)/U4 F	ryar	ntown, Ma	ryland	đ£
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service L	LO A			2. Name and		-					
			23a. Part1. Enter the disease, or	complications that car	MO	1323 A	dams 1	Fune:	ral Home	P.A. Ac	juasc	o, Mary	land Approxima	-10
	Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aa	as a conseq	uns	0		eer				Interval Be Onset and	etween
	Examiner	<u></u>	Sequentially list conditions,	b		-								
	ted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a conseq	uence or):								
	al-trai	xan	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of);								
8760,	icate be executed physician and s the burial-transit													
89	tificati ig phy as the	edic		u										
Вох	ndir use	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			1c				2	3d. Date of deliv	/ery	
	at the death by the atter	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Pregnar	h 2∏Feta nt at time of d		Ectopic pre Other (spe					Month		Year
о. О.	at the	hys	9 Unknown	9□ Unknow							İ			
ords, l	The law requires that the tte has been signed by th page 2 should be detache	þ	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the ur	nderlying ca	use give	n in Part I.		bacco us	se contribute to	the cause of bably 4	
Vital Record	has be ge 2 sh	ompieted								24a. Was a autop	sy	24b. Were aut prior to co death?	opsy findings ompletion of c	available cause of
		င် ပေ	25. Was case referred to medical							1 Yes	2 🖸 No		2□ No	
	s cert lirect	o Be	examiner?	Hospital:	estiont 2	ER/Outpatient	27.00		26. Place of Death					
O	Attending Physicien: r death. ector: After this certific: by the funeral director.	-	27. Manner of Death	28a. Date of	Injury	28b. Time of		lc. Injury Work	4 ☐ Nursing Horat	ne 5 i⊿Resid 28d. Describe h			fy)	
o	uttending death. ctor: Afte / the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month,	Day Year)	Injury	М		? es 2 □ No		. ,			
Division of	i or Attending Ph after death. Director: After th i in by the funeral	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of	Injury - At ho , etc. (Specify	ome, farm, stre	et, factory,	office	2	28f. Location (S City or Town	treet and n, State)	Number or Rur	al Route Nun	nber,
	spite ours ierel	edicai C	Check only 2 Medicel E	Physicien: To the base	s of examina	wledge, death tion and/or inv	occurred a	t the time	e, date and place, a nion, death occurre	and due to the c	ause(s) a	and manner as solace, and due t	stated.	s)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manne	stated.			License						
	F ≥ F 8		6 1016	1/1/201	) () Qu	Me		21	2076		-	signed (Month,		
			30. Name a ress of person y	to completed source	of death (tra-	232) (T	Print'	, .		3	80	200	7	
N	19 4		11345 Pent	the completed cause with \$5 \$2004	+ 104	(IV)	Mis	1	and 2	20803	3			
ú	Sta	e	31. Date filed (Month, Day, Year)	32. Re	trar's Signa	ture	1	-	+					
	Registra	_	AUG 2	6 2004	معدلات	15 1	108-7	s						

			1 - For Stata Registrar		Maryland /		rtment of I		and Mental Hy	giene	· 28	198
	Physici	an	Decedent's Name (First, Middle	e, Last)					2. Date of De Month		3. Tir	me of Death
	/Media	cal	William	Andrew	Morgan				August	22, 200	6:	15 P. M
	Examir	ier	4a. Facility Name (If not institution				4b. City, Town,			4c. County o		
	Funeral		Charlotte Ha  5. Social Security Number		S Home  Age (In yrs. last b	birthday)	Charlot If Under 1 Year			St. Ma		tata as Fasaisa
	Director		218-14-3724	<b>X</b> M 2□ F	83		Months Days		Min. (Month, Da		9. Birthplace (St Country)	
	pu ,		Usual Residence of Decedent						Novemb	er 14,19:		
	anyla shov	2	10a. State 10b. County		10c. City, To	wn or Loca	ation					de City Limits
	the M	Director	Maryland St.  10e. Street and Number	Mary's	Но	11ywo						Tes ZENO
	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show idical Examiner must be notified at	Ö		D1			10f. Zip Code	_		10g. Citizen of Wi	hat Country?	
	ms 23	Funeral	24598 Hollywood		ent Ever in U.S.	13. W	as Decedent of		in? (Specify Yes or No	USA 14 Bace	- American India	an .
9	or Ite	Ţ	1 Never Married 2 Marr	ied 1 XYes 2					gin? (Specify Yes or No , Puerto Rican, etc.)	Black	, White, etc.	.,
215-0036	rel',	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dat	es: 1945	11	Yes <b>X</b> No	Specify:		Specify:	White	
5-(	natu	Completed	15. Deceden (Specify onty highes	's Education it grade completed)	16	(Give ki	nt's Usual Occup nd of work done	during most	of working	16b. Kind of Bus	iness/Industry	
12	within ene. then "	E G	Elementary/Secondary (0-12)	College (1-4	for 5+)	life. DC	O NOT use retire	d)	-			
d 21	filed Hygi Ther		12 17. Father's Name (First, Middle,	Last)		Pri	nter	18. Mothe	r's Name (First, Middle,	Media Maiden Sumame	)	-
lan	2 6 2 0	To Be	William Alexand	er Morgan					ie Leigh Th		,	
Maryland	S E E	-	19a. Informant's Name/Relations		19	b. Mailing	Address (Street		r or Rural Route Numbe		tate, Zip Code)	
			Mary Jeanette	Norris/Dan					ad Hollywoo		20636	
ore	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Place	of Disposit	tion (Name of itory or other pla	ce)	Date	20c. Location - C	ity or Town, Stat	.e
Baltimore,	mit. Pages bartment of h ortent: If ite Injury or or		1 🔀 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)						/25/2004	Hollywoo	d. Marv	land
3att	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service	Jcensee /	( ( )	22.1	Name and Addre	ss of Facility	,			
_	20 E 2 9		23a. Part1. Enter the disease, or	ixa Jao	len &	Le	o <del>nardto</del> v	m. Ma	iner Funera <del>ryland 206</del>	il Home,	P.U.Box	2/0
			Shock, of heart failure. List	complications that cau only one cause on eac	used the death. Do sh line.	not enter	the mode of dyir	ng, such as o	ardiac or respiratory ar	rest,	Approx Interval	Between
Z	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	-a COA	JGESTIL	It i	HEART	FA	ILURE		Onset a	and Death
	Examiner		rooming in dominy	Due to (or	r as a consequence	e of):						
		ē	Sequentially list conditions,	b. — Oue to (or	as a consequence	of):						
	uted d ansit	Examiner	lany, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events			,						
ó	exec an an rial-tr		resulting in death) Last	Due to (or	as a consequence	of):						
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cal		d								
39	artifica ing ph e as ti		IF FEMALE:	1								
Вох	w requires that the death certific. been signed by the attending pi should be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐Live birti	me of pregnancy h 2 🗆 Fetal deat	h 3□Ed	ctopic pregnancy	,		23d. Date of		
- O	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	nt at time of death n	5 🗆 C	Other (specify) _			Month	n Day	Year
P. 0.	that the sed by detac	F	Part II. Other significant conditio	ns contributing to deaf	th but not resulting	in the unde	arlying cause giv	en in Part I	23a Did to	bacco use contribe	uto to the course	of dooth?
ds,	uires I sign Id be	d b	CORONARY A								☐ Probably 4	
ဂ္ဂ	w req	ete	HYPERTENSION						1450			
Division of Vital Records,	he lav e has ige 2 (	Completed by						-	autops	sy pric	re autopsy findir or to completion outh?	igs available of cause of
ā	ifficate or, pa		DIABFTES MELLI 25. Was case referred to medical	MS H, M	ENIPHERE	3L VA	SCULAR		ੋ   1□ Yes	2 2 No 1 □	Yes 21 No	
>	ysicie s cert direct	To Be	examiner?	Hospital:	atient 2 ER/O	utnationt	3□ DOA Oth	-	of Death (Check only or sing Home 5 Reside		(C:t-)	- :
0	g Ph		27. Manner of Death	28a. Date of I		Time of	28c. Injun Worl			ow injury occurred		
Š	ath. or: Af	ate	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Day roar)	Injury		kr Yes 2 ⊡ N	0			
Ĕ	or Attending Physicien: ther death. Director: After this certifica in by the funeral director, I	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place of	Injury - At home, fa , etc. (Specify)	arm, street	t, factory, office		28f. Location (Si City or Town	reet and Number	or Rural Route N	lumber,
	ital o			11/4								
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 miguical c	-xammer. On the base	s of examination ar	e, death o	ccurred at the tin	ne, date and pinion, death	place, and due to the co	ause(s) and mannate and place, and	er as stated.	se(s)
	thin 2 the	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. License					
	E 3 E 8	-	200. Diguature and title of certifier	01,	1			096-		9d. Date signed (A	wonth, Day, Year	7
4	Re	-	30 Name of addition	July sully	death the car	(Tues 2)		- 10-		08/23	12004	-
	9		30. Name and address of person v	IKBAN L	1. D	(Type, Pri	11) Y (4)	HARIA	TTE HAL	L, MD		
	Stat	e	31. Date filed (Month, Day, Year)	32. Reg	isfrar's Signature	A A	Server S	No coe	TTE HAL	-1.0		
	Registra		AUG :	3 1 2004	Marie 1	F A						

			for State	State of Maryla	and / Dep	artment o	f Health a	nd Mental Hy		2001	00100
			1 - State Registrar		<i>Ce</i>	rtificate d	or Death	1.0(2	Reg. No	2004	28 99
п	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of De Month	Da		3. Time of Death
	/Medic	cal	Curtis Rudolph 4a. Facility Name (If not institution, giv			4b. City, Tow	m, or Location of	Augus		3 2004 County of Deer	8:10P ^M
			Bayside Care Cen	ter			ton Parl			t. Mary	's
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday,		ear If Under 2 tys Hours	Min. 8. Date of Bi	rth ay, Year)		hplace (State or Foreign
a.	Director		223-28-1218 Usual Residence of Decedent		81 Yrs.			Mar. 6	, 19.	23 Vir	ginia
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	Man,	ţō	Virginia Spotsyl	vania S	potsy1v	ania					1 ☐ Yes 2 12 No
	or 284	lred	10e. Street and Number		1 - 2	10f. Zip Cod	de		10g. Cit	izen of What Co	ountry?
	be filed within 72 hours after death with the Maryland stal thygiene.  ad other than "natural", or Items 23a or 28e-f show event, Ite Mudical Evatuar must be oxitified at	Funeral Director	11305 Post Oak R	oad		22553			U.S	.A.	
	tems ferms	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No Puerto Ricen, etc.)	0-	14. Race - Ame Black, Whit	
36	rs after	by F	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No 19 If Yes, Give Year or Dates: 10		1 ☐ Yes 2 🙀	No Specify:			Specify: Tith	ito
21215-0036	2 hou	edi	15. Decedent's E	ducation ±.	946     16a. Dece	edent's Usual O	cupation		16b. K	ind of Business/	ite Industry
<u>د ا</u>	nin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	e kind of work do DO NOT use re	one during most stired)	of working			,
7	od with	Completed	12th		Mach	inest			Fee	deral G	overnment
	be filed tal Hygid d other	Be (	17. Father's Name (First, Middle, Last					's Name (First, Middle	, Maiden	Sumame)	
<u>yla</u>	should be and Mental I and Mental I amarked o	၉	Nicholas J. McMi					e Jones			
Maryland	C1 10 - 10		19a. Informant's Name/Relationship (		11			or Rural Route Numb			
o,	1 and 1 Health em 27 ther tr		Helen Gertrude Mc 20a, Method of Disposition		. Place of Disp	osition (Name o	1	North, St.		ersburg, ocation - City or	
2	90 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specil	Removal from State	cemetery, cre uantico	matory or other	place)	3/27/2004			Virginia
Baltimore,	- 투혈증		21. Signatura of Auneral Service Oce					Found and			
ñ	Depa Impo any ir		I Want Ki	220 MO1							g, VA 22407
	-M		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the do	eath. Do not en	iter the mode of	dying, such as c	ardiac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Aim	ation	P	الدو د له په دو	much			Onset and Death
	/Medical		resulting in death)	Due to (or a cons	sequence of):						
	Examiner		Sequentially list conditions,	b							
	ed sit	Jue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events	Due to (or as a cons	sequence or):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):						
/6Ú,	0 5 0	cal	· ·	d							
9	leath certificat attending phy I for use as the										
X R R	death certifica e attending ph of for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		⊒Ectopic pregna	ancy		1	23d. Date of deli	,
	0 0 0	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of 9 Unknown		Other (specify		-		Month	Day Year
J.	The law requires that the ite has been signed by thoses 2 should be detached.	Phy	Part II. Dther significant conditions of	contributing to death but not	resulting in the I	inderlying cause	given in Part I	23e Did	obaccou	ise contribute to	the cause of death?
ds,	uires that signed k d be det	d by	Atrial Fo	Culladios		and only mig dadge	givoir ii v airi.		Yes 2		obably 4 Striknown
Hecord	w requir been si should	Completed	1					24a. Was	20		topsy findings available
T T	he tay e has	mc	Hementer					auto	psy ormed?	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical				26 Place	1 ☐ Yes	2000	1 ☐ Yes	21 No
Ξ	A 00 D	ToB	examiner?	Hospital: 1 Inpatient 2	: ☐ ER/Outpatie	nt 3 DOA	0.4	sing Home 5 Resi		5 □Other (Spec	city)
	ding Ph h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		njury at Work?	28d. Describe			,
UNISION	Attending ir death. ector: Alte by the fune	catle	2 Accident investigation			М	1 ☐ Yes 2 ☐ N	0			
$\frac{2}{5}$	I or Atten after deatl Director: in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, off	ice	28f. Location ( City or To			ral Route Number,
-4	Hospital or At     24 hours after o     Funeral Direct etely filled in by		29a. Certifier 1 Certifying Pt	nysician: To the best of my l	rowledge deal	th occurred at th	a time, data and	Diago, and due to the	221122(2)	and manner as	mated
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by	Medical	(Check only 2 Medical Examone)	niner: On the basis of exam and manner stated.	ination and/or in	nvestigation, in n	ny opinion, death	occurred at the time,	date and	place, and due	to the cause(s)
	Vithin To the compl	Me	29b. Signature and title of certifier	1		1	ense number		29d. Dat	e signed (Month	n, Day, Year)
	- 11		1	1		A	1991	/	8/	26/0	4
	RN		30. Name and address of person who	/						1	
	J		James C Boyd, M			Notch Ro	ad Cali	fornia, Ma	ryla	nd 20619	9
	Sta Registr		31. Date filed (Month, Day, Year)	2004 2 Registrar's Sig	griature	Lares					

Registrar

State

30. Name an address of person who complete complete

AUG 2 5 2004

31. Date filed (Month, Day, Year)

40

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

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O.C.M.E.

August 22, 2004

111 Penn Street, Baltimore, Maryland 21201

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Horace Myers 2:157 406-051 ac 204 4c. County of Death 4a. Facility Name (If not institution, give street and number) 1811 Graduck Doctor Community Hospital Road 4b. City, Town, or Location of Death Prince Lanhom mo George 20706 8. Date of Birth (Month, Day, Yea April 22, If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year) Hours 1[**X**M 2□ F 256-09-2084 85 Yrs. 1919 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Prince George's Glenarden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7915 Grant Drive 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Thomas Myers Annie Hubbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlonia Myers (Wife) 7915 Grant Drive, Glenarden, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State Harmony Memorial Park 8/30/2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facilitatimore Funeral Services, P.A. aternore 6906 Kent Town Drive, Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) they movi a Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? myflom 1 ☐ Yes 2 X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? rena 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No

**Physician** /Medical **Examiner** 

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Certification:

Medical

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Registrar

death certificate be executed

The law requires that the

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Division of Vital Records, P.O. Box 68760.

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

other than

permit Pages 1 and 2 should be file Deparment of Health and Mental Hy Importent: If Item 27 is marked oth any financy or other treumatic event size.

Direct

Funeral

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filed within 72 hours after

Maryland 21215-0036

Baltimore,

the attending physician and had for use as tha burial-transit

Examiner ian/Medical IF FEMALE: Physici þ Completed

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypericalem

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manner of Death

5 Pending investigation

6 Could not be determined

Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? М

1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 \ \ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number D42354 29d. Date signed (Month, Day, Year) 8/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Goodback Road Lawhern mi) 20706

(sebrennicher

GEBREMICHAEL MESAN

31. Date filed (Month, Day, Year) 2 3 2004 . Registrar's Signature

		Decedent's Name (First, Middle, Last)					2. Date of De Month		Van-	3. Time of Death
Physici /Medio		MARION GRAY MCDONA	LD				AÜĞÜSI	: 16	2004	2:16PM
Examir		4a. Fecility Name (If not institution, give street and	number)		4b. City, Town, or EAST	Location of Death			nty of Death	1
Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		9. Birth	nplace (State or Foreig
Director		203-22-9893	74	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da JAN 24 Jan 2	1930 5,193	E	intry)
/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation		oun z	3,133		10d. Inside City Limit
a-fst	cto	MD TALBOT		EA	STON					X□Yes 2□N
ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	untry?
be filed within 72 hours after death with the Maryland ital Hygiene.  id other than "natural", or items 23a or 28a-f show event. Ire Medical Examiner must be redified at	rai	640 MECKLENBURG AVE	ecedent Ever in U	S 42.1		601		14.5	US lace - Amer	
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72 hours after natural, or i	Completed by Funeral	3 ☐ Widowed 4 🏋 Divorced If Yes.	Give r Dates:		I□Yes 2ŪXNo	Specify:		Spe	cify: W	WHITE
72 hc	etec	15. Decedent's Education (Specify only highest grade complet	ad)	(Give	lent's Usual Occup	durina most of worki	ing	16b. Kind of	Business/Ir	ndustry
within and the same.	m id		e (1-4or 5+)		OO NOT use retired	()		OLIN	N HOME	7
p 6 5		12 0 17. Father's Name (First, Middle, Last)	,	помы	MAKER	18. Mother's Name	e (First, Middle			<u> </u>
	To Be	TRUESDALE CLARK DAVIDS	SON			OLIVE H	BELLE G	RAY		
s 1 and 2 should be filed within the Health and Mental Hygiene. item 27 Is marked other than other traumatic event. If a	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Rura	al Route Numb	er, City or Tox	m, State, Zi	ip Code)
2 = 2 ±		SHERRILL G. BROOKS/DAUG			7 GLEBE F		N, MD 2			
Pages 1 arent of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr 1 ☐ Donation 5 ☐ Other (Specify)	om State	emetery, cren	sition <i>(Name of</i> natory or other place F CDFMATI	o)   ON CTR 8-	Date	20c. Locatio		
permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Fune at Service Licensee	D CFS	P. F.	Name and Addres		N & NEW	NAM FUN	VERAL	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	re birth 2 Feta egnant at time of d nknown	Ideath 3	Ectopic pregnancy Other (specify)				Date of deliv Month	rery Day Year
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lor Attending Physician: The law requires that the darker death.  Jirector: Atten this certificate has been signed by the inneral director, page 2 should be detached.	Completed by	tobacco disorder					24a. Was autop perfo 1 Yes	an 24b ssy rmed? 2KI No	prior to co death? 1 \(\Boxed{Types}\)	opsy findings available empletion of cause of 2 No
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or Attendiater death. Director: A din by the fu	Certification;	3 Suicide 6 Could not be	ace of Injury - At ho ilding, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (3 City or Tox	Street and Nur vn, State)	nber or Rura	al Route Number,
To the Hospital or Attencyital or Attencyital or Attency Within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier Check only 2 Medical Examiner: On the one)	the best of my kno e basis of examina lanner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the	cause(s) and r date and place	manner as s	stated. o the cause(s)
To th Within To th	Me	29b. Signature and title of certifier	1.10		29c. License			29d. Date sign		
		Matthew Fescher	MD		D 50	251		Augus	+ 17,	2004
		30. Name and address of person who completed of MATTHEW FISCHER M.	ause of death (Item	23a) (Type, I	Print) Sivi	ezs 1 tel Easi	ton Ma	mland	216	7/
		11/2/1/10 / 130/10x 111		47/11/0	0011		- 11 1 1 100	ylana	0.00	<u>'</u>

			For State Ragistrar	State of M	Maryland	•	artmen rtificat			ind M		giene Reg. N@.	anı	. 4	2 2 2	n 2_
	Physici /Medi		Decedent's Name (First, Middle, Las Beulah		Lynch	ı M	asse	nbuı	:g		2. Date of Dea Month 08	Day		ear 04	3. Time 0	f Death M
	Examir		4a. Facility Name (If not institution, give Anne Arund					Anna	Location o	s		4c.	County of		runde	el
	Funeral Director		220 20 1139	X 2 7. A	Age (In yrs. Ia 71	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 2	year)	32	Birthpl Count Ma	ace (State try) aryla	or Foreign and
	the Marylend 28e-f show	or	Usual Residence of Decedent  10a. State 10b. County  Md. Queen A	nne		Town or Lo								10	Od. Inside C	ity Limits
	with the 1 3e or 28e-	Funeral Director	10e. Street and Number 210 Newtown	Road			10f. Zip	Code 619				10g. Citiz	zen of Wh	at Count		
036	ges 1 and 2 should be filed within 72 hours efter deeth with the Marylend to of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medicial Examinar must be notified at	٥	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Tyes 2 B If Yes, Give Year or Dates	s? 🕽 No	1	Was Deced If Yes, spec 1 ☐ Yes	cify Cubar	spanic Orig n, Mexican Specify:	jin? (Spe Puerto F	cify Yes or No- Rican, etc.)			America White, 6	tc.	
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Baltimore,	Part and		20a. Method of Disposition  1 Kurial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from Stat	cer	nce of Dispo metery, crer outus	natory or o	ther place	k.		o / 0 4		cation - Ci Ltim	-		
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o uoi	anding Ph ath. or: After the		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury 2 Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1  Y	at ? ′es 2 □ N		8d. Describe h	ow injury	occurred			
Division	tel or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory	r, office		2	8f. Location (S City or Tow		Number	or Rural	Route Nun	iber,
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			30. Name and address of person who co	ompleted cause of		23a) (Type,	Print) 1 A A	uc	/	tur	nagdi	s /	Ud	21	401	
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			FaniNSOIA Keg 5. Social Security Number	PIONAL	Medical		NTET		136014		1	romi	
	Funeral Director		213-22-6355 Usual Residence of Deced		00X 1 □ M 2 🕅 F	7. Age (II	76 Yrs.	Months Days			^{Year)} 1928		place (State or Foreign ntry) RYLAND
	/land			County		10	c. City, Town or	Location					10d. Inside City Limits
775	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show cdical Ezaral or must be notitled at	Funeral Director	MARYLAND W	ORCES	TER		WHALE	YVILLE 10f. Zip Code			Og Citizan	of What Cou	1 ☐ Yes 2 No
5.5	a with	Ö	7932 OLD	OCEAN	CITY F	ROAD		218	72	,		SA	ntry r
7-10	death	nera	11. Marital Status		12. Was Dec	edent Eve	r in U.S. 13			Specify Yes or No- orto Rican, etc.)	14. F	lace - Ameri	
7 99	after or Ite	/Fu	1 Never Married 2			21X No		1 ☐ Yes 2 No		nto Hican, etc.)	İ	llack, White,	etc.
003 × E	hours urel',	d by	3 Widowed 4 Di		Year or I	Dates:	140 5				Spe	WI	HITE
18 10		Completed	(Specify only		ade completed,		(Gir	edent's Usual Occu re kind of work done DO NOT use retire	during most of w	orking	16b. Kind of	Business/In	dustry
27.2	d withir piene. r than	mo	Elementary/Secondary (	(0-12)	College	(1-4or 5+)		HOMEMAKE	-		OV	VN HOM	E.
3 × ₽	be filed tal Hygie d other	BeC	17. Father's Name (First, A	Middle, Last)	)				18. Mother's Na	ame (First, Middle, M			
Van Van	2 should be and Mental Is marked sumatic ev	To	HAROLD	В.		WHITE			ELVA		rruiti	2	
Vie			19a. Informant's Name/Re							Rural Route Number,			
	s 1 and if Health item 27 other tr	1	E. POWELL M  20a. Method of Disposition		LL/HUSB			OLD OCE	AN CITY	ROAD, WHAI			
Baltimore,	ages nt of h : If ite		1 Burial 2 ☐ Crem	nation 3	Removal from		cemetery, ci	ematory`or other pla	· 1		20c. Locatio	n - City or To	own, State
를	permit. Pages Department of Importent: If is any injury or once.		'4 □ Donation 5 □ O  21. Signature by Funeral S				DALE C	EMETERY 22. Name and Addre		0/04	WHALE	YVILL	E, MD
Ba	Dermi Depa Impo any ir		19/	1. 1.	12Kg	1			•	HOME, SELI	SVVTT T	E DE	10075
	- 4		23a. Part 1. Enter the dise	ase, or com	plications that	aused the				ac or respiratory arre		E, DE	Approximate
	Priysician		shock, or heart failur Immediate Cause (Final disease or condition	e. List only	one cause on	each line.	stone 1	leart T-	- 1/4				Interval Between Onset and Death
	/Medical		resulting in death)	-	a Due to	(or 😸 co	onsequence of):	e ari	wurk				I week
	Examiner		Sequentially list conditions		b	- M							
	bed tis	iner	Sequentially list conditions if any, leading to immediate Cause (Disease or injury	te 🕹	Due to	(or as a co	nsequence of):						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last		c	(or as a co	onsequence of):						
760,	te be executed ysician and e buriat-transit	cai E		l		(							
687	ificate g phy: as the				d								
ŏ	n cert	M/u	IF FEMALE: 23b. Was decedent pregn.	ant	23c. If yes, ou						23d. E	ate of delive	ery
P.O. Box	w requires that the death certificate I been signed by the attending physi sliould be detached for use as the b	Physician/Med	in the past 12 months 1 Yes 2 No	s?		nant at time		□Ectopic pregnanc □ Other (specify) _	у		٨	Month	Day Year
P.O.	at the	Phy	9 Unknown	1						-1111			
Ś	ires the signeral be d	by	Part II. Other significant c	a (Au	ontributing to d		hossi (	( 1 .			acco use co s 2 ⊡ No		ably 4 Dunknown
0.00	requ been shoulk	Completed		00,1-0	1		VCC 805	7 1100		-			
Hec	has bas	mpi								24a. Was an autopsy perform		Were autoprior to cordeath?	psy findings available apletion of cause of
<u>a</u>	in: Ti ficate or, pa	e Co	25. Was case referred to n	nadical						1 ☐ Yes 2	28 No		\$ No
<u>=</u>	ysicie s cert directe	OB	examiner?	-	Hospital:	Inpatient	2 ER/Outpatio	ent 3 DOA Ott		ath (Check only one Home 5 Resider		that (Crasife	4
9	g Ph ter thi	T : U	27. Manner of Death			of Injury oth, Day Yea				28d. Describe how			7
io	endin sath. or: Af	atio	2 Accident	Pending investigation	1	in, bay ro	an mijary	M 1	Yes 2 No				
Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, pace 2 should be detached for use as the	Certification;		Could not be determined	28e. Place	e of Injury - ing, etc. (S	At home, farm, s pecify)	treet, factory, office		28f. Location (Streetly or Town,	et and Nun State)	nber or Rura	l Route Number,
	hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours and hours		29a. Certifier 18 Co	ertifying Ph	ysician: To the	e best of my	y knowledge, dea	th occurred at the til	me, date and plac	e, and due to the car	use(s) and n	nanner as st	ated.
	the Hi in 24 the Fu	edicai	(Check only 2 Min	ediçai Exam	niner: On the b	nasis of exa	imination and/or i	nvestigation, in my o	opinion, death occ	urred at the time, da	te and place	, and due to	the cause(s)
	To I To I	Σ	29b. Signature and title of	certifier	$n_1$	1.1.	1111	29c. Licens			_	ed (Month, I	Day, Year)
	10.0		- NAO	rhl		74	my	1 10-	5947	>	8-5	-04	
	NA		30. Name and advess of p					ŕ	14 T T O D	MD 0100	1		
	Sta	te.	31. Date filed (Month, Day,			LUU I Registgar's S				, MD 2180	1	·	
	Registr			IG 1 1		Ben	ever /	& spa	w				

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of F			jiene	11.	202	05
			Decedent's Name (First, Middle, La	ist)				2. Date of Dea	th	J	3. Time of	f Death
	Physic -/Medi		HELEN MA	XINE	NACHBY			August	19, 2	_{Үөаг} 004	4:30	P. ^M
	Exami		4a. Facility Name (If not institution, gire	e street and number)		4b. City, Town, or	r Location of De		4c. Count			
			7157 Peace Chime			Columbia			How	ard		
	Funeral		· ·	Sex 7. Ag 1 □ M 2 🛣 F	e (In yrs. last birthday)	If Under 1 Year Months Days		in. (Month, Day,	Year)	9. Birthp	lace (State o	or Foreign
	Director		107-36-8942 Usual Residence of Decedent		57 Yrs.			Mar. 18	,1947		York	
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside Ci	ity Limits
	a-fst	ţoţ	Maryland Howard		Columbia						1 ∑ Yes	2 🗌 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number		•	10f. Zip Code	-	1	0g. Citizen of	What Coun	itry?	
	ath w 23e	la I	7157 Peace Chime	s Court		21045			U.S.A.			
	Items	Funeral	11. Marital Status	12. Was Decedent Amed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - Americ		
36	Irs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No .	I□Yes 2∰No	Specify:		Specif	y: Whi	te	
21215-0036	"natural", or	Completed by	15. Decedent's E	ducation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of B	usiness/Inc		
215	thin 7	ple	(Specify only highest gr. Elementary/Secondary (0-12)		S+) life. L	kind of work done of OO NOT use retired	)	vorking			,	
21	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show evant. The Medical Examinar must be mytilled at	Son		College (1-4or 5	School	ol Teache	r		Educat	ion		
$\subseteq$	be d a d o	Be	17. Father's Name (First, Middle, Last	)			18. Mother's N	lame (First, Middle, M	Maiden Suman	ne)		
Σ	should be ind Menta s markad umatic ev	2	David  19a. Informant's Name/Relationship (		berg		Francis			cherw		
N S	S an	1 1	Alysha DiGiorgio/	,, ,				Rural Route Number,				
Baltimore,	Health tem 27 other tra		20a. Method of Disposition		20b. Place of Dispo-	sition (Name of	1	ockville,	20c. Location -	City or Toy	wn. State	
Ë			1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		Star of I	natory or other place David Cem	سلمان معام	/23/2004 N	N. Laud	erdal	.e,	
alti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lice		,			723/2004 obert E. I	Tuana F	FLO	rida	
<b>m</b>	8 8 8 8		) Keld	7	16	000 Anna	polis R	oad, Bowie	. Marv	land	20715	
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ente	er the mode of dying	g, such as card	ac or respiratory arre	est,		Approximate Interval Betw	ө
	Physician		Immediate Cause (Final disease or condition	A	cute le	uken	nia l	lye Logen	oce s	ν	Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		1.				-2-71-61	
Н		- G	Sequentially list conditions,	b. — Due to (or as	a consequence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	-33 13 (3. 23	2 33.1034231133 31).					1		
oʻ	exec an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):							
8760,	cate be executed physician and the burial-transit	dlcal		_ d								
39 )	entifica ing ph e as ti	Med	IF FEMALE:					_		7,50		
Вох	death certifi e attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Dat	e of deliver		
Ö	e ta di	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death 5	Other (specify)			IVIOI	TACT L	Day Ye	'ear
Δ.	es that it gned by be detac		Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contr	ibute to the	cause of de	eath?
Records,		d by						1 🗀 Yes			bly 4 ⊟Ur	
000	> 0.0	olete						24a. Was an	24h V	Vere autoni	sy findings a	vailable
	o - o	Completed						autopsy perform	ed?	rior to com leath?	pletion of car	use of
		BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one		☐ Yes 2	2□ No	
o t <	dir S	ToE	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatient	3□ DOA Othe	_	Home 5 2 esider		or (Specify)		
		on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe hov	v injury occurre	ed		
sic	Attending or death. rector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be				es 2 □ No					
Division		Certification:	4 Homicide determined	building, etc	iry - At home, farm, stre :. (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural i	Route Numbe	er,
-	hours hours unerel y filled		29a. Certifier 1 Cartifying Ph	ysician: To the best of	of my knowledge, death	occurred at the time	e. date and place	e, and due to the car	ISA(s) and mar	ner as stat	ted.	
2	P F F	Medical	(Check only 2 Medical Examone)	ninar: On the basis of and manner sta	examination and/or invi	estigation, in my opi	inion, death occ	curred at the time, dat	e and place, a	nd due to the	he cause(s)	
i	within To the	Σ	29b. Signature and title of certifier	//		29c. License			d. Date signed			
				-0		02	128	26 5	legu	il 20	; 2 <del>0</del> 6	14
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, P	rint)	Par. 1	56 C	1.0	20.00	- m1	
			31. Date filed (Month, Day, Year)	EVINE, S	r's Signaturo	L.UL.	MA KYC	A 12,0	centra	, res	2109	77
	Sta Registra		AUG 20	2004	me Is A	bout						

	1 - State of Marylar Registrer Amend Item #8&19a per	informant C8: Certificate	5 979/04/tas	ntai Hygiei Reg.	2004	28206
Physician /Medical	1. Decedent's Name <i>(First, Middle, Last)</i> Kevin	Nelson, II	2	2. Date of Death Month	Day Year 2004	3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number)  9500 block of Allentown Road	Camp	m, or Location of Death Springs		4c. County of Death	eorae's
Funeral Director	5. Social Security Number  218-19-0225  Usual Residence of Decedent		ear If Under 24 Hrs. 8 ays Hours Min.	Date of Birth (Month, Day, Ye.	730/1985th 785 Mary	place (State or Foreign 17) 1and
a-f show iffed at	Maryland Prince George's	ty, Town or Location Temple Hills				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
naturel', or items 23a or 28a-f show disal Examinat must be notified at eted by Funeral Director	10e. Street and Number 3408 28th Parkway	10f. Zip Co	0748		Citizen of What Cou	ntry?
rel', or items 23a or 28a-f show Examinat must be notified at by Funeral Director	11. Marital Status  1 Marital Status  1 Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Larmed Forces?  1 Mes 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify	of Hispanic Origin? (Speci Cuban, Mexican, Puerto Ri No Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify:	
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", any injury or other traumatic event, the Medical Exc once.  To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual O (Give kind of work a life. DO NOT use n	one during most of working stired)		. Kind of Business/Ir	ndustry
Mental Hyg arkad other tic event, To Be C	17. Father's Name (First, Middle, Last)  Kevin Anthony Nelson	Beaten	18. Mother's Name (A	First, Middle, Maid		ck
atin and w	19a. Informant's Name/Relationship (Type, Print) Cynthia Wyrick (Mother)	19b. Mailing Address (St 3408 28th Pa	reet and Number or Rural F arkway Temple	Route Number, City Hills,	y or Town, State, Zi, Maryland	20748
nent of He ant: If item ary or oth	1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of commetery, crematory or other	Place) August	28,	Location - City or To	
Departr Imports any inji	21. Signature of Funeral Service Licensee		dress of Facility Lee d Alexandria	runeral	Home Inc	
attending physician and to use as the burial-transit and to use as the burial-transit and to use as the burial-transit and to use as the burial-transit and the burial transit and the burial transit and the burial transit	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consect of the conditions) of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the condi	uence of):				Interval Between Onset and Death
ed led	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnat 1 Live birth 2 Feta 4 Pregnant at time of d	ll death 3 □Ectopic pregn leath 5 □ Other (specifi	)		23d. Date of delive Month	ery Day Year
be d	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause	given in Part I.		o use contribute to the	
ate has page 2				24a. Was an autopsy performed?	prior to cor death?	psy findings available npletion of cause of 2 No
within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification; To Be Co	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28 Accident investigation (Society Control of Could got be	1.01 PM	njury at 28d No 27 No 28d 28d	5 Residence  I. Describe how inj	din Multar	collision
within 24 hours after To the Funeral Director Completely filled in Medical Cert	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my known one of the control of the best of examiner: On the basis of examination and manner stated.	wledge, death occurred at th tion and/or investigation, in r	e time, date and place, and ry opinion, death occurred	due to the cause( at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
Tot	29b. Signature and title of certifier  Pametre Southfull, m.D.		onse number		Date signed (Month, 1)	
Pin	30. Name and address of person who completed cause of death (Item Pamela E. Southall, m.D.  31. Date filed (Month Pax Year) 6 2004  32. Wistrar's Signa		treet, Baltir	more, Mar	ryland 212	201

		1 - For State Registrar	State of M			artmen	t of H			ental Hy	giene Reg. Nd	nol	201	207
Physi	oion	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Year	3. Time	
* /Med		Robert Dellie Norris								August	21	2004	9:45	A. M
Exam	niner	4a. Facility Name (If not institution, give s		)				Location of	of Death			County of Dee		
		St. Mary's Nursing Cer 5. Social Security Number 6. Sex		ne (In vrs. I	ast birthday)		ardto 1 Year		24 Hrs.	8. Date of Bir		. Mary':	thplace (State ountry)	or Foreign
Funera Directo			{M 2□F	73	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 30,	ıy, Year) 1931		ountry) ' yland	
4 6		Usual Residence of Decedent												
rylan ihow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits s 2 ☑ No
Ba-f s	50	Maryland St. Mary's		Mec	hanicsv			_		1			1	
or 2	Director	10e. Street and Number					Code					en of What C	ountry?	
ITIC Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland la! Hygiane. Id other then "netural", or Items 23a or 28a-f show event, tre Medical Examinar must be notified at		13901 Ryceville Road	12. Was Decedent	- Everie II	e 12 1		0659	isoanic Ori	ain? (Sa	orty Vas or No	USA	4. Race - Am	erican Indian	
P 2 2	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces	?	3.	If Yes, spe	cify Cuba	in, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, Whi		
hours after tural; or tra	b	3 ⊠ Widowed 4 □ Divorced	1 □Yes 2 □ If Yes, Give Year or Dates:			1 🗌 Yes	2 No	Specify:				Specify: W	nite	
2 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	dent's Usu	al Occup	ation during mos	t of worki	na	16b. Kir	nd of Business	/Industry	
Ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT L	se retired	1)		9				
fig Z IZ IS-19-19  e filed within 72 h  al Hygiane.  other than "natu	S	12			Mus	ician		10 Math	ul - No m	/Fires & Sindelle		ertainm	ent	
be fill Had out	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame)		
Mary Iditio Z. I.Z. 13-0030 d.2 should be filed within 72 hours af th and Mental Hygiane. 7 is marked other then "natural, or traumatic event, the Medical Evann traumatic event, the Medical Evann	10	Herbert Eugene Norris  19a. Informant's Name/Relationship (Ty	ma (Print)		10h Mailie	an Addres	c (Street			ille N o		Town State	Zin Code)	
Mar d 2 sh th and 7 is m traum	1	Diane Tucker/Daughter	pe, enn)			-				icsville			zip doddy	
re, Mary s 1 and 2 shou f Health and M item 27 is mar other traumati	-	20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of			ate		cation - City o	Town, Stete	
ages ant of tr: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		emetery, crer les Mem				ugust	24,2004	Leona	rdtown,	Maryland	
parmit. Pages 1 and Department of Heall Important: if item 2 any injury or other	once.	21. Signature of Funeral Service Licens	holine	2	M	ATTINO	SLEY C	ss of Facilit SARDINE Maryl	R FUN	ERAL HOM	E, P. <i>A</i>	., P. O	Box 27	0,
Physicia		23a. Part1 Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final	ne cause on each	line.	n. Do not ent	er the mo	de of dyin	g, such as	cardiac o	or respiratory a			Approxim Interval B Onset and	etween
/Medica Examine	al er	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence a consequence	uence of:	- 0	x =	eny	d	usec	ne			
/ <b>bU,</b> e be executed /sician and buriat-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c. Due to (or a		uence of):	L								
	cal		d											
ath cert	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 \( \tilde{V}\)\( \text{No} \) 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fete	ldeath 3[	∃Ectopic p ∃ Other (s		′			2	3d. Date of de Month	alivery Day	Year
dS, F.C. I			ntributing to death	but not res	ulting in the u	inderlying	cause giv	en in Part I			tobacco u Yes 2[		to the cause of	death?
w require been signature	ete									24a. Was	an	24b. Were a	utopsy finding	s available
	Completed									1 Yes	200 No	death?	completion of s 2 \(\sigma\) No	cause of
VII SICIAN CONTIL	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpat	i 2 🗆	FD/Outsetus		Oth Oth	00		Check only		Other /Sa	noifu)	
on or ding Phys h. After this funeral di	tion: To		28a. Date of In (Month, D	jury	28b. Time o Injury		28c. Injur Wor	y at		me 5 Res 28d. Describe			eciiy)	
DIVISION OT VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of lo	njury - At ho atc. <i>(Specif</i>	ome, farm, str	reet, facto	ry, office			28f. Location City or To	Street and wn, State,		Rural Route Nu	ımber,
le Hospital 24 hours :	Medical C		sician: To the besiner: On the basis and manner s	of examina										)(s)
To the Ma within 24 I To the Fu completely	Me	29b. Signature and title of certifier				29		e number	^ /		. 4	-	th, Day, Year)	
•		1 ASha	N			C	D	470	66	2	8	- 23 -	04	
SAS		30. Name and address of person who c	ompleted cause of	death (Iter	n 23a) (Type,	Print)							·····	
り		Dr. A. D. Shah St. M				, Leo	nardto	own, Ma	rylar	d 20650				
5.1	State istrar	WELLET 03 72	32. Regis	trar's Signa	ature	Shan	N. J.							

		For Stata Registrar	State of Marylai	•	artment of F		, ,	iene	4 28208
Physic /Medi		Decedent's Name (First, Middle, Last)     MATTIE	С.	NIBLET	Т		2. Date of Death Month	Day	3. Time of Death 1832 M
Examin Funeral		4a) Facility Name (If not institution, give s Ploninsula Regional 5. Social Security Number 6. Sex	Medical 7. Age (In yrs	Center  Last birthday)	SOUS If Under 1 Year	r Location of Dear	8. Date of Birth	4c. County o	1 Death  THUD  9. Birthplace (State or Foreign Country)
Director		214-28-1804  Usual Residence of Decedent  10a. State 10b. County	M 2XF 86	Yrs.	Months Days	Hours Min	FEB. 22,	1918	MARYLAND  10d. Inside City Limits
the Maryla 28a-f shor	rector	MARYLAND WICOMIC		WILLAR			10	og. Citizen of Wi	1 X Yes 2 □ No
If I I I I I I I I I I I I I I I I I I	by Funeral Director	36285 PINE STR	EET  12. Was Decedent Ever in the Armed Forces?	J.S. 13.	218		Specify Yes or No- to Rican, etc.)	USA 14. Race	- American Indian, , White, etc.
hours after		1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  15. Decedent's Educ	1 Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	WHITE
ild K. I.K. 13. a filed within 72 a Hygiene. other than "na rent, the Medic	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done DO NOT use retired LTRY GROV	during most of wo	orking	POUI	
should be file and Mental Hy marked othe	To Be C	17. Father's Name (First, Middle, Last)  CLARENCE	COOPER			STELI		BRATTE	EN
IVIC Ith a 27 is		19a. Informant's Name/Relationship (Ty) SUE W. COOPER/NIEC  20a. Method of Disposition	E 20b.	8395		E ROAD, V	VILLARDS, Date 2	MARYLAN	
Dallinole, permit. Pages 1 au Department of Hea Important: If item any injury or other once.		1 🛣 Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State	ALE CE		8/8	3/04	WHALEYV	VILLE, MARYLAND
Action, sale be executed why sician and hysician and the burial-transit the burial-transit was a sale of the burial-transit which was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit was a sale of the burial-transit wa	Ical Examiner	23a. Part I. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conse	quence of):		ng, such as cardia			Approximate Interval Between Onset and Death
OI VICAL INCIDIOS, F.O. BOX 00 100,  Physician: The faw requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy	1		23d. Date Monti	
law requires that as been signed be 2 should be deta	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			oute to the cause of death?
ding Physician: The law. h. After this certificate has b	e Completed	25. Was case referred to medical						ed2 de	ere autopsy findings available or to completion of cause of ath?  Yes 2 2 No
Physicia this cert	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	00	ath <i>(Check only on</i> e Home 5 ☐ Resider		(Specify)
fune fune	ertification:	27. Manner of Death  1. Natural 5 Pending investigation  3 Suicide 6 Could not be 4 Homicide	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	28b. Time o Injury	M 1 □		28d. Describe how	eet and Number	or Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical Cert	29a. Certifier 12 Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat	h occurred at the tir vestigation, in my o	ne, date and place	e, and due to the car	use(s) and man	ner as stated. d due to the cause(s)
To the To the To the Comple	Med	29b. Signature and title of certifier	7. Tylera	W)	29c. Licens	e number 59 475	29	d. Date signed (	Month, Day, Year)
M		30. Name and address of person who con YVONNE M. TYLER	/			SALISBUR	Y, MD 218	01	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		, ,	K	, - =		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 24, 2004 12:15 P.M OPPENHEIM LENA ELLA /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Washington Hagerstown Williamsport Nursing Home #Under 24 Hrs. 8. Date of Birth (Month, Dev. Yeer) April 23,1909 If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days 1□M 2**∑**F 95 217-32-5323 Yrs. Germany Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 112 South Prospect Street 21740 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after on Hygiene.

Other than "natural", or itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fine Clothing Designer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hyant: If Item 27 is marked oth Be Sasse Simon Augusta 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 617 Cornwallis Lane, Foster City, CA. 94404 Mark Oppenheim Grandson 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dapartment of the Important: if ite any injury or of 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) B'Nai Abraham Cemetery 08-26-04 Hagerstown, Maryland 22. Name and Address of Fecility Andrew K. Coffman Funeral Home, Inc. 21. Signature of Funeral Service Licensee noel 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Renal Failure Iweek Examiner Examiner Colitis 3weeks Hospital or Attending Physician: The law requires that the death certificate be assected
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attendion physician and the attending physician and the for use as the bunal-transif Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown deep venous thrombosis of 24a. Was an autopsy 24b. Were autopsy findings Completed aveilable prior to completion of cause of deeth? performed? Osteoporosis 2 340 1 Tyes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Uursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3∏ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier cynthe Kuttner-Sands mo D47451 August 24, 2004 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Williamsport Nursing Home, Kuttner-Sands MD Cynthia Williamsport, Maryland

Registrar

State

DHMH 16 Rev 6/95

Maryland 21215-0020

Baltimore.

P.O. Box 68760.

Records,

Division of Vital

32. Registrer's Signature

		-	For State	State of Marylar	•	artmen			nd Me		iene	0.01		
	1		Registrar  1. Decedent's Name (First, Middle, Las	et)		imour	0, 0	Cairi	2	. Date of Deat		<del>U U !</del>	3. Time	of Death
	Physicia	an								Month	Day 26	2004		) P M
	/Medic		4a. Facility Name (If not institution, give	eth Mary Oros		4h City	Town or I	ocation of		ugust	1	county of De		) <u>F</u>
	Examin	er		street and number)				200411011 01	Dodai					
	h=		Union Hospital  5. Social Security Number 6. Se	ex 7. Age (In yrs.	last hirthday		ton 1 Year	If Under 24	4 Hrs. 8	Date of Birth		Cecil	irthplace (State	or Foreian
	Funeral		1	□M 21XF 72	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, Oril 27,	Year)	M	Country) arvland	
	Director	. }	219-32-7710 Usual Residence of Decedent	12		1				111 2//	1.502		aryranc	^
	and and		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limits
,	Mary Sh	ō	Maryland Baltimo	ore Ba	altimor	`e							1 🖾 Y€	s 2 No
	or 28a-f show	Director	10e. Street and Number			10f. Zip	Code			10	0g. Citize	en of What 0	Country?	
3	Sa or		613 South Savage	Street		2	1224				I In	ited S	States	
	be filed within 72 hours after death with the Maryland half Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be mailfied at	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			panic Origi	in? (Speci	fy Yes or No- can, etc.)		4. Race - An	nerican Indian,	
_	r Iter	Fun	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No	1				Puerto Ri	can, etc.)		Black, Wh	nite, etc.	
3	o'le	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2∭ No	Specify:			S	Specify: W	Mhite	
5	72 hours after natural', or Ite dical Examine	Completed	15. Decedent's Ed		16a. Dece	dent's Usua kind of wo	al Occupat	tion	of working		16b. Kind	d of Busines	s/Industry	
2	Ved.	ple	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT us	se retired)	ning most c	or working					
7	yiene. r than "	E O	Lienternary/occordary (o 12)	2	Adm:	inist	rativ	e Ass	sista	nt	He	ealth	Care	
<u> </u>	Hygi other	0	17. Father's Name (First, Middle, Last)					18. Mother	's Name (i	First, Middle, N	Maiden S	umame)		
<u>a</u>	lid be lental ked o	To B	Albert P. Oros,	Sr.				Hele	n Sal	kowski				
	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If flem 27 Is marked other than or other traumatic event, the Me		19a. Informant's Name/Relationship (		19b. Maili	ng Address	(Street ar	nd Number	or Rural I	Route Number,	City or	Town, State	Zip Code)	
Ĕ	nd 2 ullth a 27 Is r tra		Elaine M. Canton	e/Sister	P.O.	Box !	521,	Perry	vill	e, Mary	land	3 2190	)3	
<u>ē</u>	f Health item 27 other tr	1	20a. Method of Disposition	20b.	Place of Dispo	osition (Nar	ne of ther place	) 7.	Dat		20c. Loca	ation - City o	or Town, State	
2	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State Sc	cemetery cre acred H esus	leart	of	/   Al	ugust 2004	31,	Balt	imore	, Mary	land
	nit. Parartmen ortent: injury		21. Signature of Funeral Service Licer		2:	2. Name an	d Address	of Facility	,				,	
g	permit. Page Department of Importent: If any injury of once.			Heck						als, P.		M=		1001
			23a. Part1. Enter the disease, or com-	plications that caused the dea						et ,_E1k respiratory arre		_ Mary	Approxim	ate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		4.							Interval B Onset an	
F	Physician /Medical		disease or condition resulting in death)	, a	DCG)	yse,	210						1300	145
	Examiner			Due to (or as a conse	quence of):	n	ani	000					21	noto
		<u></u>	Sequentially list conditions,	b. Due to (or as a conse	number off.		1110	C/_					100	cers.
	ed Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/	2.472								1 1 1 1 1	200
	and and I-trar	xan	that initiated events resulting in death) Last	c. Due to (or a conse	guence of);	_		_					1-90	(A1
3/60,	ate be executed hysician and the burial-transit	ical E		Rienst	Car	0.0							155	IPAR
æ	physicate physicate	73		_ d((	MIC	C. J.				·			1 2	, 40
×	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancy						23	3d. Date of d	elivery	
Rox	atten atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3[	□Ectopic pr						Month	Day	Year
o	at the de by the a tached	ysic	1 ☐ Yes 2 A No 9 ☐ Unknown	9□ Unknown	dou 51	_ O ( Sp.								
<u>.</u>	hat ti ed by detac		Part II. Other significant conditions of	contributing to death but not re	sulting in the u	underlying d	ause giver	n in Part I.		23e. Did tob	acco us	e contribute	to the cause of	f death?
ည်	ires that signed t d be det	1 by	Huner tensia	n sportar	nenia	7				1 □ Ye	s 2 X	No 3□	Probably 4 [	□Unknown
5	w require been si should t	etec	- 17 ggreen je risto	1, 10001101		(				24a. Was a		Odb Wore	autonou findina	an avadable
Vital Records,	alaw hast e 2 s	Completed by				<del></del>				autops perform	V	prior to death	autopsy finding o completion o	cause of
		S									No		s 2 No	
=======================================	sl <b>cian</b> : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				-		Check only on		-		
5	Physic this c	2	1 ☐ Yes 2 No	Inpatient 2L	ER/Outpatie		the same of	4 🗀 Nui:		e 5 ☐ Reside	_		pecify)	
_	ding Ph h. After th funeral	-in	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1	28c. Injury Work	?		d. Describe ho	winjury	occurred		
20	Attendik death. ctor: A y the fu	cati	2 Accident investigatio 3 Suicide 6 Could not b	10		М		es 2□N	_	t Location (Ct		Alumbasas	Over 1 October 11	
Division of	I or Attene after death Director: I in by the	Certification:	4 Homicide determined		nome, tarm, st ify)	reet, factor	y, office		20	If. Location (St. City or Town		Number or I	nurai noute ivi	Jinber,
	urs a		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	 			- 1 11 - 1		1-1	ad due to the ex				
	Hosp 14 ho Fune Fune	ica	(Check only 2 Medical Exam	hysician: To the best of my kr miner: On the basis of examin										∋(s)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29b. Signature and title of certifier	and manner stated.		29	c. License	number		2:	9d. Date	signed (Mo	nth, Day, Year	)
	1 V S		230. Signature and the processine	///		1	2000	CA	7.0	4	A	154	2 1	M4
			" W M	1 m		L	W.	170	101	/	uge	11/0	14,00	$\mathcal{N}_{ }$
	11		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type	, Print)	4 5	ite	210	EIL	tin	Mr	2/0	721
	7		31. Date filed (Month, Day, Year)	32. Registrar's Sign	1//// nature	1 11	. 04	11/6	117	CIC	1011		0/	4/
	Sta Regist	ate rar	CED A 7 2		1			. :						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For Stete Registrar			Cen	tificate of L	ealth and I Death	,	Reg. No.	01, 28211
sicia		Decedent's Name (First, Middle		ricio Mel	ızin.	Ortiz		2. Date of De Month	Day	Year 3. Time of Death
edic min		4a. Facility Name (If not institution			VIII	4b. City, Town, or	Location of Death	Augus		2004   8:25 P
		31 West Irving	Street				Chase			tgomery
al or		5. Social Security Number 216-90-0263	6. Sex 2□ F	7. Age (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Da Jan 10	rth ay, Year) , 1966	Birthplace (State or Foreign Country)     El Salvador
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn ar Loc	ation				10d. Inside City Limits
	Director	Maryland Princ	e George'			La	nham			1 ⊠ Yes 2 □ No
	Dire	10e. Street and Number 9314 Wyatt Dr	ive			10f. Zip Code	706		10g. Citizen of	What Country? USA
	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. W	/as Decedent of Hi Yes, specify Cubar		pecify Yes or No	o- 14. Ra	ice - American Indian,
	by Fur	1 XNever Married 2 Mar 3 Widowed 4 Divorced	If Yes G	2 XNo		Yes, specify Cubar			orian ^{Speci}	ack, White, etc. ify: White
			nt's Education	168	a. Deced	ent's Usual Occupa	tion	luin n	16b. Kind of E	Business/Industry
	Completed	Elementary/Secondary (0-12)	College Completed	1-4or 5+)	life. D	aind of work done of O NOT use retired, Painter	uring most or wor.	King		Private
	Bec	17. Father's Name (First, Middle,	,				18. Mother's Nan	ne (First, Middle	, Maiden Suma	
	To	Fransisco O						onsuelo		
		19a. Informant's Name/Relations Consuelo Ortiz				Address (Street a Wyatt Dr:				n, State, Zip Code)
ĺ		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation	3 □Removal from	State 20b. Place comete	of Dispos ery, crem	ition (Name of atory or other place	e)	Date	20c. Location	- City or Town, State
		`4 □Donation 5 □ Other (5	Specify)			e Cremato			Belts	ville, MD
ouce.		21. Signature of Uneral Service	Licensee	2./		Name and Addres				
		23a. Pan. Enter the disease, o	r compliations that	caused the death. Do		013 Annay r the mode of dying				Approximate
1	Į.	Immediate Cause (Final	t only the cause on	each line.	+	1.	hernel			Interval Between Onset and Death
il r		disease or condition resulting in death)	a. Due to	(or as a consequence	of):	sug 1	010000	1909		
	L	Sequentially list conditions,	b	4.	-					
	nine	Sequentially list conditions, any leading to in reclaim cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequence	oll):					
	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequence	of):					
	70		d							
	Med	IF FEMALE:								
ı	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregnancy birth 2 Tetal deat	h 3□				1	ate of delivery onth Day Year
	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nant at time of death nown		Ectopic pregnancy Other (specify)				
	y Physician/Medic		9□ Unkr	nown	5 🗆	Other (specify)	n in Part I.	23e. Did	tobacco use con	ntribute to the cause of death?
	by	9 Unknown	9□ Unkr	nown	5 🗆	Other (specify)	n in Part I.		tobacco use con	ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
	by	9 Unknown	9□ Unkr	nown	5 🗆	Other (specify)	n in Part I.	1 🗆 24a. Was	Yes 2□No an 24b.	- V
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State Registrar DHMH 17 Rev 1/2001

THE DOURE M, king
31. Date filed (Month, Day, Year)

AUG 23 2004

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2030 M **Physician** 2004 Mae Pritchett August Nancy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mounico mad in FENIN SUIA RIGIONNI SAUSSUR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 M 2 F 10, 1950 Director 212-56-1962 54 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 Yes 2 □ No MD Dorchester Director Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5239 Gypsy Dr. 21613 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a any injury or other treumatic event. If a Marcel Exambre context. U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) manufacturing associate electronics mfq. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin O. Wilson Maggie Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Pritchett daughter in law 3661 Karen Circle, Linkwood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Dorchester Memorial Park 8/23/04 * 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Dint Mun K. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Houte Heute my acrd al Hours Interetis /Medical Examiner Due to (or as a conse luence of): actions dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ď 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has h autopsy s certificate ha performed? Yes 2 No 2□ No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 08/19/04 D 41721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHAN PAYLOS SAUISBURY MD 400 E. SHORE DR 2004. Registrar's Signature 31. Date filed (Month, DaAVB) 2 3 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 9:45 A M Merle Horst Petre 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14315 Clear Spring Road Washington Williamsport If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. **Director** 66 Dec.29,1937 Maryland 213-40-7093 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits worde ! rthan "natural", or items 23a or 28a-f ehov the Medical Exercipations to notified at 1 ☐ Yes 2 X No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14315 Clear Spring Road 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Dairy Farmer Agriculture rmit. Pages 1 and 2 should be filed v partment of Health and Mental Hygie portent: If item 27 Is marked other t y injury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russel Valentine Petre Emma Baer Horst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy J. Petre/Wife 14315 Clear Spring Rd. Williamsport, MD 21795 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation ) 5 ☐ Other (Specify) Pinesburg Menno. Cem. 8-27-2004 Williamsport, Maryland permit, Departn Importe any inju 21. Sign sure of Funeral Se 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or weart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Olloblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any teacher to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760. physician Certification; To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy igned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rmed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of cermier 29c. License number 29d. Date signed (Month, Day, Year) 5H-4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.Z. Kutzela no 31. Date filed (Month Date Year) 5 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State o	f Marylar		artment of I		nd Mental F	lygieņe	11111	282	14
			Decedent's Name (First, Middle,)	ast)					2. Date of	Death		3. Time of	Death
	Physicia /Medic		Harriett Eliza	beth Po	sev				Augus	t 24.		8:27	Ам
	Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of			. County of Death		
			Washington Adv				Takoma		41 les	M	ontgomer		
	Funeral Director		5. Social Security Number 218-52-5669	.Sex 1 □ M 2 💢 F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month,	Birth Day, Year)	9. Birthr	place (State o.	r Foreign
			Usual Residence of Decedent		04				reb. Z	.0, 13	920   Engl	and	
	nyland how	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	Od. Inside Cit	·
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ם מ	filed Hygi other	မ င်	17. Father's Name (First, Middle, La	st)		Homen	liakei	18. Mother	's Name (First, Mide				
<u>8</u>	d Mental marked c	To Be	Augustus Leven	ett				Annie	A. Aller	1			
Maryland	d 2 should th and Mer 7 is marke treumatic	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree		or Rural Route Nur		or Town, State, Zip	Code)	
	ss 1 and 2 of Health item 27 i		Kenneth L. Posey	-Son		6431	Fairborr	Terra	ice, New (				<b>ļ</b>
Baitimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1	☐Removal from	State 20b.	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ace)	Date	20c. L	ocation - City or To	own, State	
	permit. Pages Department of I Importent: If its any injury or o		*4 □Dogation 5 □ Other (Spe	cify)	Tri	nity M	emorial	Gdns. (	08-27-200	4 Wa	ldorf, M	arylan	d
g	permi Depar Impo any ir		21. Signature of Plineral Service Li	ensee MO	1391	1	2. Name and Addr duntt_Fur	ess of Facility neral f	lome Waldorf, N				
			23a. Part1. Enter the disease, or co	mplications that	caused the dea	th. Do not ent	er the mode of dyi	156, k ing, such as c	laldorf, N ardiac or respirator	1D 206	604-0156	Approximate	3
	Pnysician		shock, or heart failure. List or mimediate Cause (Final	ily one cause on e	each line.							Interval Bety Onset and D	
	/Medical		disease or condition resulting in death)	a. Gangr Due to	ene of	LXTrem quence of):	1ties						
	Examiner		Sequentially list conditions	b. Hepar	in indu	iced Th	rombotic	Throm	bocytopen	ia			
	sit s	Examiner	Sequentially list conditions, if any, leading to him solidate cause. Enter Underlying Cause (Disease or injury that solidated as a solidated to the solidated as a solidated to the solidated as a solidated to the solidated as a solidated to the solidated as a solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the solidated to the so	Due to	(or as a nonsec	juanca of):							
_	be executed ician and burial-transit	хаш	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):							
68/6U,	ate be executed hysician and the burial-transit	cai E		4	,	,							
200	death certificate e attending phys id for use as the			U.									
ŏ	death certifical attending phy d for use as th	M/UE	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Ectopic pregnanc	·v		-	23d. Date of delive	*	
E		sick	in the past 12 months? 1 ☐ Yes 2 ☐ <b>X</b> No		nant at time of o		Other (specify)	· · · · · · · · · · · · · · · · · · ·		-	Month	Day Y	'ear
л Э	res that the de signed by the a be detached f	Physician/Med	9 Unknown			tain - i- ah	- d- & d	orania Bandi	22a Di	d tabaasa .	use contribute to th		
JS,	requires that the	by	Part II. Other significant condition	s contributing to u	leath but not res	suiling in the ti	ndenying cause gr	ven in Paπ I.			use contribute to tr XNo 3 □ Prob		
cord		Completed					-· · · · · · · · · · · · · · · · · · ·		_				
Ľ	The law ate has b	mp								as an topsy rformed?	death?	impletion of ca	use of
Vital		မ C	25. Was case referred to medical	1	<del></del>			26 Place	1 ☐ Yes of Death (Check onl	— <b>∧</b> −	1 Yes	2 No	
	> 0 T	0 8	examiner? 1  Yes	Hospital: 1 🛣	Inpatient 2	ER/Outpatier	nt 3 DOA		sing Home 5 Re		6 □Other (Specifi	v)	
o c	ding Phy h. After thi funeral	n: T	27. Manner of Death 1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of	28c. Inju Wo	iry at	28d. Describ			.,	
<u> </u>	Attending ir death. ector: After by the fune	catic	2 Accident investiga 3 Suicide 6 Could no	tion				Yes 2□N	0				
UIVISION	- +	Certification:	4 Homicide determin	280. Place	e of Injury - At h ing, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory, office			(Street an Town, State	nd Number or Rura e)	l Route Numb	ier,
	spitel ours a serel (		29a. Certifier \ \ \nabla \subseteq Certifying	Physician: To the	a hest of my kn	owledge deat	h occurred at the ti	ime date and	place, and due to the	20 021160/6	and manner as st	rated	
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 Medical Ex	eminer: On the b	asis of examination	ation and/or in	vestigation, in my	opinion, death	occurred at the tim	e, date and	d place, and due to	the cause(s)	
	withir To th comp	Me	29b. Signature and title of certific	1			29c. Licen:	se number		29d. Da	te signed (Month,	Day, Year)	
			* ***********************************	MARK	$\wedge$		28	588	3	8/2	24/12		
4	A 0 1		30. Name and address of person with							1	1100		
- 1	716		Dr. Anjum Qazi	<b>/7610</b> (	Carroll	Ave.,	Takoma P	Park, M	ID 20912				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 (	2004	Registrar's Sign	A A	parke						

			1- State of Maryland / Dep	partment of Health and Mertificate of Death		ene . 28215	
П	Physici	an	1. Decedent's Name (First, Middle, Last)  Willie Edgar Price		2. Date of Death Month	Day Year	
4	/Medic Examin		4a. Facility Name (If not institution, give street and number) 3948 Watertank Road	4b. City, Town, or Location of Death Manchester	August 2	28, 2004 10:30 Am 4c County of Death Carroll	
H	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		
	Director		220-18-9544 10XM 2□F 80 Yrs.  Usuel Residence of Decedent	Months Days Hours Min,	8. Date of Birth (Month, Day, ) DeC • 21,	1923 Virginia	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer is and by notified at once.	ŏ	10a. State 10b. County 10c. City, Town or L  MD Carroll Manche			10d. Inside City Limits 1 ☐ Yes 2 💆 No	
		rect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	
		by Funeral Director	3948 Watertank Road	21102		U.S.A.	
Maryland 21215-0036			11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
		Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupetion e kind of work done during most of worki DO NOT use retired) andscaper	ing	Sb. Kind of Business/Industry Home Improvement	
		3e C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
		To Be	Emory Price			th Heath	
				ling Address <i>(Street and Number or Rura</i> 8 Watertank Rd <b>.,</b>			
Baltimore,	ges 1 au forthez fritem or othe		1 M Burial 2   Cremation 3   Bernovatiron State	ematory`or other place)   Sept	Date 1, 20	Dc. Location - City or Town, State	
ij	nit. Pagartment ortant: injury a.			Cemetery 2004	1 W.	hite Hall, MD	
<b>B</b>	Depar Depar Impor any ir		Harfenstain 2	Name and Address of Facility J.J. Hartenstein 24 Second St., N	Mortua <u>New Free</u>	ry,Inc. edom,PA 17349	
	ি ysician /Medical Examiner		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):				
		iner	Sequentially list conditions, it is a least in the sequence of the cause. Enter Underlying Cause (Disease or injury			Jen	
ó	sate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
Records, P.O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai	d				
		b Be Completed by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
			Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobad	cco use contribute-to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	
					24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No	
			25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death		0 DOhn (0-1/4)	
		on: To	27. Manner of Death  1  Natural 5  Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No				
		catio					
		Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To t To t	Σ	29b. Signature and title of certifier  M	29c. License number  D 18822	29d	Date signed (Month, Day, Year)	
	8		30. Name and address of person who completed cause of death (Item 23a) (Type	nel Rd, Parker	to MA	21/20	
0.	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 2004 Services	& Louis			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Dealt 1. Decedent's Name (First, Middle, Last) August 16 Day 2004 Year PEASE 9.00 AM **Physician** DAISY /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CLINTON CLINTON NURSING HOME 8. Date of Birth (Month, Day, Feb 24, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign St Complete Cheals 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F 88 212-66-9834 Director Barbados Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28e-f show tXYes 2 □ No Fort Washington MD Prince George's Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 0/10 20744 United States 1606 Aragona Blvd death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₹\$No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "netural", or Items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: the Medical Exer XXXXWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Importent: If item 27 is marked other then any injury or other traumetic event. Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Margaret Riley Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1606 Aragona Blvd Fort Washington MD 20744 Holiday Jones/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 8/17/2004 Alexandria 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Alexander S. Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner lero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No bremo vostros Ton Hospitel or Attending Physiclen: . Was case referred to medical examiner? 26 Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 | Homicide 🚅 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08-16-2004 PO37-066 who completed cause of death (Item 23a) (Type, Print) 6188 O +ON HILL RO #701 OPAIGBEOGU NOW HILL MN 70746

Registrar

State

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3. Registrar's Signature

		For State	State of Maryland	d / Dep		lealth and	Mental Hy	_	NI. 20217
Physic	ian	1. Decedent's Name (First, Middle, Last) Allen Oueen					2. Date of De Month August	ath Day	3. Time of Death 2004 10:15PM
/Med Exami	ical	4e. Facility Name (If not institution, give str Heritage Harbour		ehab	4b. City, Town, o			4c. Count	y of Deeth  Arundel
Funeral Director		213-32-4336	7. Age (In yrs. Ia	Yrs.	Months Days	If Under 24 H Hours M	in. (Month, Da	ıy, Year)	Birthplace (State or Foreign Country)  Maryland
Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Ar		10d. Inside City Limits  1☐17es 2☐No					
with the 3a or 28a	i Director	10e. Street and Number 1894 Generals Hi		ražo1	10f. Zip Code 21401			10g. Citizen of USA	What Country?
72 hours after death with the Maryland 72 hours after death with the Maryland natural, or Items 23a or 28a-1 show offer Examitive must be notified at	by Funeral		. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or No erto Rican, etc.)		ice - American Indian, ack, White, etc. ify: Black
Maria Para	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0·12)	pation during most of v d) ment 0	working nerator	Anne A	Business/Industry Arundel Co. Of Public			
Maryland CIC d 2 should be filed within th and Mental Hygiene. 7 Is marked other than treumatic event, the M	To Be Col	9th 17. Father's Name (First, Middle, Last) George A. Qu	een			E1	lame (First, Middle izabeth	маМен Suma Gant	me)
12 mg 2	-	19a. Informant's Name/Relationship (Type Allen Queen Jr.	(Son)	3269	Rivers	ide Av	e. Some	rset, 1	^{1, State, Zip Codel} 02726 Massachusetts
altimore, mit. Pages 1 ar partment of Hea portant: if Item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	Met	osition (Name of smatory or other plate to rematory)	y 8/	Date 19/04		- City or Town, State	
Deartimot Department Important: if any injury or			seMc0483		Wm Ree 821 WES	se & S	ons Mort	uary,	P.A. 21401
Physiciar /Medica		23a. Part 1. Enter the disease, or complic shock, or hear failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  Due to (or as a consequ	ارد	ascul	CCC	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
ficate be executed trace by physician and trace is the burial-transit	cai Examiner	Sequentially list conditions, is any, seating to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to	efe	- Ce	serter alli	Marson		years rears.
death certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnanc	у			tate of delivery Ionth Day Year
I HECOTIAS, P.O. The law requires that the set has been signed by the page 2 should be detach.	þ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the	underlying cause gr	ven in Part I.		tobacco use cor	ntribute to the cause of death?
	Completed						24a. Was auto perf 1 🗆 Yes		. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
VITA siclan: certifica irector,	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 XNo  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	ER/Outpatie 28b. Time Injury	of 28c. Inju	ner: 4 Nursin	Death (Check only g Home 5 ☐ Res 28d. Describe		71
Division of el or attending Phy s after death. Il Director: After this ed in by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, s	treet, factory, office			(Street and Num wn, State)	nber or Rural Route Number,
To the Hospitel within 24 hours a To the Funeral Completely filled	edical (		er: On the best of my known or: On the basis of examinat and manner stated.						
To the within To the comp	Me	29b. Signature and title of certifier	- H	0	29c. Licen	4051	29d. Date signed (Month, Dey, Year) S1804		
		30. Name and address of person who con	18ee 1667	Cro	ofton Cen	ter, G	often,	Marylon	d.
Regis	State strar	31. Date filed (Month, Day, Year) AUG 19 20	32. egistrar's Signa	ture	bouts				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician **QUEEN** MELVIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 10XM 2□ F Director 83 21 1921 WASHINGTON, DC 578-09-8557 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director PRINCE GEORGE'S LANHAM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? U.S.A. items 23e 5008 BALTIMORE LANE 20706 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status □xYes 2 □ No Yes, Give 1 Never Married 2 Married 9 1 Tyes 2 No Specify **Black** 3 Widowed 4 Divorced Year or Dates: naturai 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) U S Postal Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Teresa Queen McClenlan Oueen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 5008 Baltimore Lane Lanham, Maryland 20706 item 27 I Jane Bailey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of It
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 8/27/04 Suitland Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NON HEMMORLE disease or condition resulting in death) OBYS /Medical Due to (or as a consequence of) Examiner 0 DBETES MELLITUS TEA.L Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit YEAL 55625 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month Year Day 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 TYes 2 No hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide filled in 24 hours a Funeral I 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MDD 31069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 1100 Mercantile Lane Suite 135 Largo mD 20774 Bone George MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 4 2004

State of Maryland / Department of Health and Mental Hygiene State 8-20-04 Registrar Amend # 1. Per Phys. PGC cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Antoine Dupree Richards Jr. Year **Physician** 04484 M 2004 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES FORT WASHINGTON FUNT WASHINGTON HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1995) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 X M 2 ☐ F 8 Washington, D.C August 19. Director 578-27-2380 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at XXYes 2 No Director Maryland Prince Georges Accokeek 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö death with 15219 Derbyshire Way 20607 United States Items 23e Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If ifem 27 is marked other than "natural; or iten eny injury or other traumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: **Black** Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Elementary School Student Education 2nd grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Antoine Depree Richards, Sr. Katina Sherrie Dailey 19a. Informant's Name/Relationship (Type, Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoine D. & Katina S. Richards 15219 Derbyshire Way; Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery July 30,2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. Karramak 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLE Physician /Medical Due to (or as a consequence of) **Examiner** HYPOXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ mental Repardation/ Cerebral Palsy 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? PANHYPOPITUITARISM 24a. Was an autopsy performed? SUBGLOTTIC STENOSIS DEVELOPMENTAL DELAY 1 Yes 1 Yes 2₽ No 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2/SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To hours after death. uneral Director: After this ly filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide within 24 hours a To the Funeral C Fo the Hospital t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 784/2004 056005 mara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 LIVINGSTON RD. FORT WASHINGTON, MD 20144 R.O'MARA JUSAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sporte AUG 2 0 2004 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ELLA ELIZABETH REYNOLDS AUGUST 16 2004 1:20p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗗 F Yrs. 84 220-18-8431 1919 Director Maryland Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylar th and Mantal Hygiens. It has the Marylar Hygiens 77 is maturel; or Items 23e or 28e-1 show 17 is material. An institute in the marylar is the martitle in the market in the second the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the second in the secon 1 ☐ Yes 2- No MD Kent Galena Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31705 Olivet Hill Circle 21635 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Work Someone else's home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George E. Briscoe Charity L. Carroll Pages 1 and 2 should I nent of Health and Meni ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra George Briscoe (brother) P.O. Box 184 Galena, MD. 21635 20b. Place of Disposition (Name of cometery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 8/20/04 West Chester, PA. Memoriāl Park 21. Signature of Mineral Service Licens a 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech
To Most Cross St. Galena, MD. 21635 M00510 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS **Physician** DISUNSE YUTH S /Medical Due to (or as a consequence of): **Examiner** GASTROINTESTINAZ MONTHS OLKBDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner led by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. certificate has been signed rector, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTAUCTIVE PULMONARY 1 Yes 212No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Cther: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٩ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jonet 00057509 Trocay TMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14M63 E. WATHINGTON AVE, CHESTERTOWN, MD 21620 LACEY

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) AUG 1 7 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vaar **Physician** 28 2004 3:30A Violet Jean Rovito August /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 18111 Three Notch Road St. Mary's Lexington Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Wre Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Director 212-66-4654 50 27, 1953 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 ehow eny injury or other traumatic event, it a Medical Examinar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18111 Three Notch Road 20653 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖫 No 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert Stone, Sr. Helen Bean Talent ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald A. Rovito, Sr. / Husband 18111 Three Notch Road, Lexington Park, MD 20653

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 1 BBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's 08/31/2004 Ridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy perform 1 ☐ Yes 2X No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Certification: To 1 Yes 2X No 3□ DOA 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20986 Labe 08-30-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) his Notin Rd. - Howard MD 20636 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2004 Registrar

DHMH 17 Rev 1/2001

or Attending Physician: The law requires that the death certificate be executed

Hospitel

To the

SOE

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** August 25, 2004 7:40 A Ratliff Gerald Wayne /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Nursing Center Leonardtown 8. Date of Birth (Month, Day, Year) Nov. 11,1949 If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1X M 2□ F Maryland Director 215-56-9627 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent; if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Medical Examinar must be notified at once. or 28a-f show 1 ☐ Yes 2 No Director St. Mary's Lexington Park MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20653 United States 21094 Winding Way Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rudy Ratliff Dorothy Twilley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (BROTHER) 21493 Elegant Court Lexington Park, MD 20653 Ronald E. Ratliff 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 27, 2004 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXI Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Crematory Charlotte Hall, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Brinsfield Funeral Home, P.A. David A. Goff MO 1095 22955 Hollywood Rd. Leonardtown, MD 20650 23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one payse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINOMA OF The LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No s after death. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by 1 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie SAO 171458 August 27, 2004 30. Name and address of ersor who completed cause of death (Item 23a) (Type, Print) 25365 Point Lookout Rd. Leonardtown, Maryland 20650 William D. Boyd, M.D.31. Date liled (Month, Day 32. Registrar's Signature State NG 8 1 2004 ) 8

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Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Anna Marie Smith 18, 7:00 A M August 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium at South River Edgewater Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-11-1923 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Hours Min Months Days 191-16-7231 Yrs. 80 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Directo Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Itema 23a 21401 924 Beacon Way USA filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White þ 3 Widowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Homemaker other vith and Mental Hve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic even Honora Cremin 2 Jeremiah Sexton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Regina C. Bullock/ Daughter 3743 Park Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 200 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 8-19-04 Edgewater, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home ODC word 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death allion a **Physician** /Medical **Examiner** al Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit 00 the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed/ certificate 2 No 1 Yes 2 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of s after death. 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 (Z) Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) the th 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 19 2004

**ORIGINAL** 

Registrar

		1 - State State Registrar	of Maryland		artment of H			giene Reg. Ng. 0 ()	4 2822L		
Db		Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death		
Physic /Medi		Merle L. Shumaker					August	18 ^{pay} 200	4 7:30PM M		
Exami	ner	4a. Facility Name (If not institution, give street and not 2476 Bell Branch Road			4b. City, Town, or Gambril	ls			Arundel		
Funeral Director		5. Social Security Number 176–16–4701 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. In 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		0,1921 S	9. Birthplace (State or Foreign Country) omerset, Pa.		
and	7	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	eation			·	10d. Inside City Limits		
Marylan f show	ō	Maryland Anne Arundel	Gam	brills	5				1 Tes 2 No		
with the sa or 28a	Direc	10e. Street and Number 2476 Bell Branch Road			10f. Zip Code 21054	4		10g. Citizen of W USA	hat Country?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, it a Madical Exartitat mast be motified at any ping.	y Funeral Director	Armed F  1 Never Married 2 Married 1 Yes, G	2 □ No live		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black	- American Indian, k, White, etc. White		
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2 should and Men le marke	Ι.	19a. Informant's Name/Relationship (Type, Print)			ng Address (Street				State, Zip Code)		
Tand 2. Health are om 27 le ther trau		Priscilla Snyder/Daught  20a. Method of Disposition		- h	Breton Aversition (Name of	ve., Dav	Date	95616	City or Town, State		
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permit. P Departme Importan any njuri		21. Signature of Juneral Service Licensee	a.h.				eorge P.	Kalas F	uneral Home		
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Myoca (or se consequ	idial	Jula	tion			Interval Between Onset and Death Minutes		
Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.									
othe Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	utcome of pregnal birth 2  Fetel gnant at time of de nown	death 3[	∃Ectopic pregnancy ] Other (s <i>pecify)</i>			23d. Date Mon	o of delivery th Day Year		
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Co	29a. Certifier (Check only one)  29a. Certifier 1 Certifying Physician: To the Check only one) 1 Medical Examiner: On the and received and received the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	ne best of my know basis of examinat nner stated.	wledge, deat ion and/or in	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and man date and place, a	nner as stated. and due to the cause(s)		
To the within To the comple	Med	29b. Signature and title of certifier	amo	- W	29c. License	0018	566	29g. Date signed	(Month, Day, Year) 118,2004		
		30. Name and address of person who completed car	use of death (Item	23a) (Type,	AdmiRed	Cocha	ne Dr.	AUNTAN	118,2004		
St	ate	31. Date filed (Month, Day, Year) 32.	egistrar's Signal			-00.86-44		170 10 51 100			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year august 1052 PM **Physician** 2004 Janis Faye Snell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🕅 F 56 Kentucky July 20,1948 Director 275-50-9534 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10b. County 10a State or than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 62 Madison Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married hours after 1 ☐ Yes 2 No Specify Specify: White Maryland 21215-0036 þ 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) le marked other than Hygiene. Personal Residence Homemaker 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental P Alice Paytner Pages 1 and 2 should be ment of Health and Menta ant: If Item 27 Is marked Issac Ramsburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hagerstown, Maryland 21740 101 Broadway Paulletta R. Stroop 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt.Moriah Union Twp.Cem. 8-30-04 Falmouth Kentucky ō Deparment of Important: If any in ury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home permit 21. Signature 1331 Fastern Blvd. N. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sapri Physician /Medical Due to (or as a consequence of): Examiner Lagrenas Pretzble Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 ☐ Probably 4 ☐Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 400 1 ☐ Yes certificate 26. Place of Death (Check onl. one Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No 3□ DOA Certification: To After this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide filled in by 4 | Homicide within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 24, 2004 P108) a -ONTEMO 343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST MAGERSTOWN NO 21740 ~ 340 DATTA VASANT 31. Date filed (Month Per 727) 6 2004 32. Figistrar's Signature State Registrar

	State of Maryland / Department of Health and Me  1- State Registrar  State of Maryland / Department of Health and Me  Certificate of Death	ental Hygieı Reg.	2001	28226	
Physician /Medical	1. Decedent's Name (First, Middle, Last)  ALBERT JOSEPH STIVERS	2. Date of Death Month AUGUST	Day Year 22 2004	3. Time of Death 8:27p M	
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  30326 Chesterville Bridge Rd. Millington	R Date of Birth	4c. County of Death  Kent  9. Birtho		
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f Health and Mer itam 27 is marke other traumatic	19a. Informant's Name/Relationship (Type, Print)  David Stivers (son)  19b. Mailing Address (Street and Number or Rural R  30326 Chesterville  20a Method of Disposition  20b. Place of Disposition (Name of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of Date of D	Bridge		llington 1	
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within 24 hours after To the Funeral Directompletely filled in by Medical Certif	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	and place, and due to	o the cause(s)	
To To	29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. Do 9 0 2 4	2	Pate signed (Month, I	O4	
	Robert McDonald, MD 30 East Dover St. Eas	ton, MI	21601		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day 18 AUGUST 2004 1:30PM M JOHN WARREN STEVENS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs 047-18-7234 Director 81 Feb. 3, 1922 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MDKent Kennedyville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29166 Belchester Road 21645 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene.

Other then "neturel", or ite 1 Tyes 2 No If Yes, Give Year or Dates: 1943-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yacht Broker Yacht Sales permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent: If item 27 is marked oth-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Heman Warren Stevens Mary Elizabeth Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Warren Stevens/son 1118 Crawford Road, Crawford, WV 26343 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 08/20/04 Stevensville, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Fellows Helfenbein & Newnam Funeral Home, PA 130 Speer Road, Chestertown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Due to (or as a consequence of): MINURS /Medical Examiner phumonits piration Sequentially list conditions, any lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2. No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Nother (Specify) HOSPICE 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52860 August 19, 2004 DSeymon MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508 Idlewild Avenue Easten, MI) a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Runo Olof August 1109:20 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehab Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 8/5/1910 Birthplace (State or Foreign Country) Days Hours **X** M 2 □ F 94 162-01-7090 Finland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29269 Glenco Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify: 3€ Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Woodworker Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Isak Evald Siren Vera Viktorina Soderstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kenney PO Box 673 Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Cremation □8/14/2004 Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows Helfenbein & Newnam Funeral Home, P.A. 370 West Cypress Street, Millington, MD 21651 Approximate Interval Between Onset and Death ardiac or respiratory arrest, a

Department of H Importent: If ite eny injury or ot once.

**Physician** 

/Medical

Examiner

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Funeral

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IF FEMALE:

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

**Funeral** 

**Director** 

f Health and Mental Hygiene. Item 27 Ie marked other then "neturel", or Items 23e or 28e-f ehow other treumetic event, the Madical Examinat must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Ie marked other then "neturel", or Items 23

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

this

death.

within 24 hours after deat To the Funerel Director:

with the Maryland

Pnysician /Medical **Examiner** or Attending Physicien: The law requires that the death certificate be executed burial-transit and

Examine Be Completed by Physician/Medical the as nse atter for u the signed by the 은 Medical Certification:

Ba. Part1. Enter the disease or c shock, or heart failure. List o	omplications that caused the death. Do not enter the mode of dying, such as cannot one cause on each line.
nmediate Cause (Final sease or condition sulting in death)	aDue to pr v a consequence of):
equentially list conditions, any leading to immediate use. Enter Underlying	b. Du lo (or as a consequence of:
ause (Disease or injury at initiated events sulting in death) Last	c.  Due to (or as a consequence of):
	d

23b. Was decedent pregnant in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 Fetal death

23c. If yes, outcome of pregnancy

Hospital: 1 | Inpatient

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably

23d. Date of delivery

Month

	24a. Was an autopsy performed?
26. Place of Death (C	Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Day

Year

	1 Tes	2 No	1 ☐ Yes 2
6. Place of Death (C	heck only	one)	
Nursing Home	5 🗌 Resi	dence 6	G ☐ Other (Specify)

27. Manne of Deal 1. Natural 2 \(\subseteq\) Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office		28f. Location (Street and Number or Rural Route Numb City or Town, State)
29a. Certifier	1 Certifying Phys	ician: To the best of my kno	owledge, death occurre	ed at the time, d	ate and plac	ce, and due to the cause(s) and manner as stated.

Other:

3 Ectopic pregnancy

29a. Certifier (Check only one)	12 2	Certifying Pr Medical Exar	minar: (	n: To the On the ba and mann	isis of a	mamination and/or investig	irred at the time, date and pation, in my opinion, death	place, and due to the occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and	ı tiylə	of certifier	)	^	1	0	29c. License number		29d. Date signed (Month, Day, Year)

2 ER/Outpatient 3 DOA

death (Item 23a) (Type, Pril)

AD 17 SHEAR PD 5725 CHASTEN POWN, MD

Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician August 11, 2004 4:00p John Zook Stoltzfus /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kennedyville Kent 28465 Comegys Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 07/11/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Yrs. 75 PA 212-42-9726 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f shov other treumatic svent, the Medical Examiner must be nutitived at 1 ☐ Yes 2 ☐ No Directo Maryland Kennedyville Kent 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 28465 Comegys Road 21645 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Zook John P. Stoltzfus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tre 28645 Comegys Road, Kennedyville, MD 21645 Naomi Stoltzfus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a Method of Disposition 1 Nation 2 □ Cremation 3 □ Removal from State
1 1 □ Donation 5 □ Other (Specify) Harmony Church Cemetery 8/14/2004 Millington, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, MD 21651 osen Jellan Approximate Interval Between Onset and Death 23a Jan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) +100 **Physician** Mocardia /Medical Due to (or as a consequence of) **Examiner** Orongry 52459 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit 1460 05 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 1 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 0M10 cate has l page 2 s autopsy performed3 certificate 1 ☐ Yes 2 1 No Hospitel or Attending Physician: : After this certification of funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural within 24 hours aries ____ After to the Funerel Director: After _____ After fulled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) NO055524 30. Name and address of person who obmbleted cause of death (Item 23a) (Type, Print) 21635 main 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			Please Type or Print in Black	•	9
			1_ State	partment of Health and Mental I Pertificate of Death	2001 20000
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. U U U U U U U U U U U U U U U U U U U
	Physici		Ralph I Snyde	<b>★</b> Month	1 Day Year 1 11 200 M
	/Medic Examin		da. Facility Name of not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Baltimore Renabilitation and Extended Care Center	Baltimore	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Davs Hours Min. (Month	Day, Year) Country)
	Director		217-52-2829 RJM 2LF 56 Yrs Usual Residence of Decedent	Nov 5	5, 1947 Virginia
	yland yland		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	e Mar a-f st	ctor	Maryland Carroll Elder	sburg	1 □Yes 2X No
	or 28	by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23e	eral	835 Sarah Drive  11 Marital Status 12. Was Decedent Ever in U.S. 1	21784	USA
<b></b>	fter de	Fune	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	No- 14. Race - American Indian, Black, White, etc.
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	filed Hygid Other ant,	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	Agency  Idle, Maiden Sumame)
lan	lid be lental rked c	To Be	Lynus H. Snyder	Margaret Joh	nson
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	1 and 2 Health tem 27 l			Sarah Dr. Eldersburg,	MD 21784
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr ence.		1 SurBurial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of Date place)	20c. Location - City or Town, State
III.	t. Pa rtmer rtent:		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	erans Cemetery 8/17/2004	
Ba	permi Depa Impo any ir		John K Held	Pritts Fu	meral Home & Chapel, PA
	* · ·		23a. Part 1. Enter the disease, or complications that caused the death. Do not	412 Washington Rd. Westmenter the mode of dying, such as cardiac or respirator	ry arrest. Approximate
13	Pnysician :		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	PNEUMONIA	Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions, if any, leading to immediate  b. PATUSO'S  Due to (or as a consequence of):	DISEASE, END ST.	AGE 10 years
	ted	Examiner	Cause. Enter Underlying Cause (Disease or injury	- X	
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89	feath certificate h attending physion	Physiclan/Medl	IF FEMALE:		
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant 12st. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ⊡Ectopic pregnancy	23d. Date of delivery  Month Day Year
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O	ding Phy h. After thi funeral	tlon	1 Natural 5 Pending (Month, Day Year) Injur		be how injury occurred
Division	Atten r deal sctor;	iflca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office 28f. Locatio	n (Street and Number or Rural Route Number,
ā	tel or s afte el Dir	Certification:	4   Homicide building, etc. (Specify)	City of	Town, State)
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier (Check only (Check only 2   Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated.
	thin 2	Medical	one) and manner stated.  29b. Signalure and title of certifier	29c. License number	29d. Date signed,(Month, Day, Year)
)	78787		Addison Co Tan VI. A.	714958	17 2 1971/4
-	1 2		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	Hugust 11, 2007
	~ ~		AURORA C. TAN 3900 LOC	HPAVEN BOULE VARD	BALTIMORE MD 21218
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	(	
	Registr	ar	AUG 2 0 2004 Straw &	Sporte	

		4	For State Registrar	State of Mar	ryland / Depa <i>Cer</i>	artment of H <i>rtificate of L</i>		_	iene	2000
			Decedent's Name (First, Middle, Last)	)				2. Date of Death	4004	3. Time of Death
Phys /Me	siciar edica		Thomas Joseph	Schiro				August 2	4, 2004 Year	8:45 P M
1	mine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea		4c. County of De	
			Charlotte Hall Vet		e		tte Hall		St. Mary	/'s
Funer			5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	n. (Month, Day,	Year) 9. B	Birthplace (State or Foreign Country)
Direct	tor	-	190-14-08/0	1M 2U F   {	83Yrs.			Nov. 27,	1920 Ne	ew York
and		-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ncation			<del></del>	10d. Inside City Limits
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the A		3	/irginia   Fairfax		<u>Annandal</u>	10f. Zip Code		10	ng. Citizen of What C	
with	į	2		ina Count		22003			-	Journity !
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ter d	1	5	1 Never Married 2 Married	Armed Forces?	1	If Yes, specify Cuba	n, Mexican, Pue	nto Rican, etc.)	Black, Wh	
US af		2	3 Nidowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1 9	212-45	1 ☐ Yes 2 🂢 No	Specify:		Specify: Wh	ite
Maryland 21215-0036 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 27 is marked other then "neturel; or retreumetic event, the Macilial Exam	3	e -	15. Decedent's Edu	ıcation	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of Busines	:s/Industry
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land be Mental rked o	3		Lorenzo Schiro				August	ina (unav	ailable)	
aryla should and Men s marke		1	19a. Informant's Name/Relationship (Type	rpe, Print)	19b. Mailir	ng Address (Street a		Rural Route Number,		, Zip Code)
and 2 and 2 salth a n 27 is			Lawrence A. Schiro	o - Son	7710	Annanda 16	e Mains	Court, An	nandale,	VA 22003
Fe s 1 a other		1	20a. Method of Disposition	_	20b. Place of Dispos				Oc. Location - City o	
Pages nent of ont: if its			1 N Burial 2 □ Cremation 3 □ R 1 4 □ Donation 5 □ Other (Specify)			rans' Ceme		30-04 C	heltenham	. MD
<b>₽</b> _ 5 € 6	oi	1	21. Signature of Funeral Service License	110000					110100	3 115
Den Den sur	Bice	1	No. 1. M. Bust	)	′ ∣Hu	Name and Addres	ral Home	MD	22204	-
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58760, ficate be executed physician and s the burial-transit	100	2								
	1	ealcai		J						
	/84/		IF FEMALE:	23c. If yes, outcome of	pregnancy				23d Date of di	-15
Box eath cert attendin for use	0	P nysician/m	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
P.O. hat the de d by the delached	195	70.5	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ne or death 5	Tother (specify)				
that the ed by deta	6	Ē	Part II. Other significant conditions con	ntributing to death but	not resulting in the ur	nderiving cause give	an in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records, The law requires t te has been signe age 2 should be	1	ຣ	1 1	eart 7	failure					Probably 4 Unknown
cord w requir	9	Completed	X 4 T							
Recelaw	2	=	Dementia					24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Thr Thr cate	2	3						performe 1 ☐ Yes 2/	ed? death? □No 1 □ Ye	
on of Vital Reding Physicien: The Properties of After this certificate the funeral director, page	a	0	25. Was case referred to medical examiner?			Oth		eath (Check only one)	)	
of \ Ohysic this c al dire	F	2	1 163 2 2 2 140		2 ER/Outpatient		4 ursing i	Home 5 Residen		ecify)
on c	2	5	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	Year) 28b. Time of Injury	Work		28d. Describe how	v injury occurred	
Division of Vital in or Attending Physicien: 1 after death. Director: After this certifical in by the funeral director, p.	Cortification	Sal	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No			
Divisit	1		4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre <i>(Specify)</i>	set, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	łural Route Number,
urs al	0							1		
Hosp 4 hot Fune ely fi		2	(Check only 2 Medical Examir	sician: To the best of a ner: On the basis of e	xamination and/or inv	occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and du	is stated. le to the cause(s)
Division of Vital Records, P.O. Box ( To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Modical	בַּ	one)	and manner state	d.					
To vit		2	29b. Signature and title of celtifier			29c. License	number	530	d. Date signed (Mon	ith, Day, Year)
						DC	10520	97	8/25	12004
100 = 1			30. Name and address of person who co	impleted sause of dea	1. > 1.	Print)	.1 0	1	100	1
MP5+			Janelle Bell,	MU	100 170	DSPIJZU	re	Mundo	TVRO n	1D 2067x
	State	9	31. Date filed (Month, Day, Year)  ALIC 9 6 2	32. Redistrar's	s Signature	hart .				

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2004

Schiro, August 24th

DHMH 17 Rev 1/2001

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State Registrar address of person

31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

			For <b>Amend Items 2</b> 1 - Stata Registrar	3atater, Ma	nyland/Ber Ce	attes of artificate of	<b>69/04df</b> Death		giene	. 20222
			1. Decedent's Name (First, Middle, Last	)				2. Date of De	ath	3. Time of Death
	Physici /Medi		ALLEN OLIVE	R SMITH	III			AUGUS	Day Yea	0 10 11
	Examir	ıer	4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County of De	ath
			Union Hospita			-			Cecil	
	Funeral Director		5. Social Security Number 6. Se 222-44-1339	X 7. Age	(In yrs. last birthday 46 Yrs.	Months Days	If Under 24 H Hours M	in. (Month, Da	y, Year)	irthplace (State or Foreign Country)
			Usual Residence of Decedent		40		J	Mar 24	1 1958 M	lary1and
	how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Be-fa	Ş	MD Cecil		Elkton					tX Yes 2 No
	or 24	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	s 236	Ta .	115 Clinton St			21921			U.S.A.	
	Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	- 14. Race - An , Black, Wh	
936	hours after death with the Maryland lural, or flems 23e or 28e-f ahow at Exandher mast be mulfitled at	þ	3 Widowed 4 XDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🐼 No	Specify:		Specify:	Black
Maryland 21215-0036	72 hours "natural", dical Ex-	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
21	within 7 ene. than "r	n ple	(Specify only highest grad	College (1-4or 5-	lite	o kind of work done of DO NOT use retired	during most of w	vorking	Universi	ty
7	be filed within 72 ho ital Hygiene. id othar than "natur event, it e Modical	ပ်	12		Foo	d Servic		er	Food Ser	-
and and		Be	17. Father's Name (First, Middle, Last) Allen O. Smith	T w				ame (First, Middle,		
ž	2 should be and Mental is marked aumatic ev	ပ	19a. Informant's Name/Relationship (Ty		10h 14ail	inn Addungs (Otto A		Webster		
Z	id 2 s lth an 27 is i		Donna Smith						ar, City or Town, State,	
<u>ค</u>	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		20a. Method of Disposition	(ex-	20b. Place of Disp	osition (Name of		North E	ast, MD. 20c. Location - City of	21901 Town, State
Baltimore,	Pages ent of nt: If i		1 ☐ Burial 2 🛣 Cremation 3 ☐ F  3 ☐ Other (Specify)	lemoval from State		matory`or other plac cemation		21/04	Smyrna,	
Ħ	permit. Pages Department of H Important: If its any injury or of once.		21. Signature of Funeral Service Licens	90)	ra de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de la caractería de	2. Name and Addres				
m	Depa Impo any is		1 Tol	MO	0510 1	alena Fu 18 Wast	Cross	Home of	Stephen Lena, MD.	L Schaech
			23a. Part. Enter the disease, or compleshock, or heart failure. List only of	cations that caused	the death. Do not en	ter the mode of dying	g, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		e Myocard	ial Infar	ction			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		<u>.</u>	Sequentially list conditions,	Due to (or se a	consequent of):	Cardiomyo	Darny	•		
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	6.		Congestive	e Heart	Failure		
Ć.	execu n and ial-tra	Exal	that initiated events resulting in death) Last		consequence ):	lypurtens:	ion	. 1	0	
8760,	cate be executed obysicien and the burial-transit	dical		. 3	erece C	mye hi	He	et fact	de l	
	rtifica ng ph as th	Med	IF FEMALE:							
Вох	eath certif attending for use as	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2		DEctopic pregnancy			23d. Date of de	1
o.	the a	/sicl	1 Tyes 2 No	4□Pregnant at t 9□Unknown		Other (specify)	-		Month	Day Year
P.O.	The law requires that the death certificate has been signed by the attending to bage 2 should be detached for use as	by Physiclan/Me	Part II. Other significant conditions cor	tributing to death but	t not resulting in the u	nderlying cause give	on in Part I	23e Did to	bacco use contribute t	o the cause of death?
ds,	urres tha signed I Id be det	d b	46	Au	• • • • • • • • • • • • • • • • • • •	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 □ Y		robably 4 Unknown
Ö	w requir been si should	lete	CIRCL					24a. Was a		utopsy findings available
æ	the lay	Completed						autops perfor	sy prior to med? death?	completion of cause of
<u>ia</u>	certificate	a)	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only on		s 2 No
<u>_</u>	physics this ce al direc	ToB	examiner?	ospital: 1  Inpatien	t 2 ER/Outpatie	nt 3 DOA Othe			ence 6 Other (Spe	əcify)
0	ding PI h. After ti funeral	iuo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer) 28b. Time o	f 28c. Injury Work	at ?	28d. Describe ho	ow injury occurred	
Sio	tand leath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				'es 2 □ No			
Division of Vital Records,	after of All	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st. (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
_	I of the flospital of Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Č	29a. Certifier 1 Sertifying Phys	ician: To the best of	my knowledge deat	h occurred at the tim	e date and place	and due to the	ause(s) and manner a	s stated
	l o the Hospita within 24 hours To the Funerel completely filled	edical	(Check only 2 Medical Examinate)	ner: On the basis of a	examination and/or in	vestigation, in my op	inion, death occ	curred at the time, d	late and place, and du	e to the cause(s)
	To th Comp	Me	29b. Signature and title of certifier			29c. License		2	29d. Date signed (Mon	th, Day, Year)
)			Jui cen Ho	m MI	)	PO	4823		8/18/0	4
	2		30. Name and address of person who co	mpleted cause of de			7	01 1	ilc10 1	. ( ) 101 . 1
				HSU MI		West 1	man	00. 8	HYON F	14 0194
	Sta Registra		31. Date filed (Month, Day, Year)  SED 0.7 2004	32. Registrar	s signature	metal.				

			1 - State Amend Item 20	State of Mary Ob per FH,G	and / Dep 335,09/0	artmen Mineat	t of H <b>hh</b>	ealth a D <i>eath</i>	ınd M	ental H	ygiene	: : :		282	34	
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of D	Da	v	Year	3. Time o	f Death	
10	/Media		Michele Lynn Smith							August	19,	200	4	5:40	A M	
	Examir	er	4a. Facility Name (If not institution, give s	•				Location of	f Death		4c. County of De					
	Funeral		122 Kline Boulevar  5. Social Security Number 6. Sex			Frederick  If Under 1 Year   If Under 24 Hrs.				R Date of Righ			ederick  9. Birthplace (State or Foreign			
L	Director		215-92-6902 1 M 2 F 40 Yrs. Months Days Hours M							Jan. 2	2, 19	64 ]	Cour	land	Jr 1 Oreign	
	irylan show	_	10a. State 10b. County	10c. City, Town or Location							10d. Inside					
	88-1 s	cto	Maryland Frederick	Fr	ederick	-								1 A Yes	2 🗆 No	
	with ti	Dire	10e. Street and Number 122 Kline Boulevar	1	10f. Zip					_	izen of W	hat Cour	itry?			
	eath	eral		12. Was Decedent Ever	2170		enanic Orig	in? (Spe	oifu Vas ar N	USA	14 Race	- Americ	an Indian			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic event. Ite Madical Examines cust be notified at ances.	by Funeral Directo	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? If 1 ☐ Yes 2 🛣 No			Was Decedent of Hispanic Origin? (Specify Yes o f Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☑ No <i>Specify:</i>					or No- 14. Race - American Indian, Black, White, etc.  Specify: White				
Š	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occupation  kind of work done during most of working					16b. K	ind of Bus				
21	ithin ner	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired,	) most	UI WOIKII	ig						
2	lled w lygier her tl	S	12 17. Father's Name (First, Middle, Last)	Barten			ender  18. Mother's Name (Fir.					pita:				
anc	ntal Hed of	Be	David Omer Kline					18. Mother Carol			e, Maiden	Sumame	)			
2	should ad Me mark matic	10	19a. Informant's Name/Relationship (Ty)	ne Print)	19h Maili	ing Address	1			Route Numb	hor City o	r Tours	tato Zin	Cadal		
<u>8</u>	od 2 s Ith ar 27 is r trau		Carol Kline, mother	•						ederic			1701	Code)		
<u>6</u>	f Healitem		20a. Method of Disposition	20	b. Place of Dispo	osition (Nan	ne of	1		ate				wn, State		
Baltimore,	Page ient o nt: If ry or		1 ☐ Burial 2 🖾 Cremation 3 ☐ R  3 ☐ Other (Specify)	emoval from State	cemetery, cie Smithsbu	-			08/2	1/2004	Fred	leric	k. M	[arv]aı	nd	
a a	permit. Departmimporta Importa any inju		21. Signature of Funeral Service License			The second section is			-	ney and Basford Funeral Ho						
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	/Medical Examiner  the private franching the private franching the private franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching franching f	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, a.y, reading to himburd acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Meta	sequence of):	Vario	sche an (	Cano	če.							
. בסע	death certifi e attending i id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown									23d. Date of delivery Month Day Year			r'ear	
as, r	es ngi pe	ρ	Part II. Other significent conditions con	tributing to death but not	resulting in the u	inderlying ca	ause give	n in Part I.						e cause of d		
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al ne	ician: The lav certificate has rector, page 2	e Completed	25. Was case referred to medical							auto perfe 1  Yes	psy ormed? 2 X No	pri	or to cor ath?	osy findings a npletion of ca 2 \( \text{No} \)	ause of	
>	99 (0.:=	To B	examiner?	lospital:	2 🗌 ER/Outpatier	st 3∐ D∩	△ Othe			Check onle		: Othor	/Conside			
DIVISION OF VITAL RECORD	al or Attanding Physician: : after death. I Diractor: After this certifice d in by the funeral director,		27. Manner of Death  1 Natural 2 Accident S Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time o		Bc. Injury Work		21	8d. Describe				7		
	al or Atta s after dea ii Diracto ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined						8f. Location ( City or To			or Rura	Route Numi	ber,		
•	To the Hospital or A within 24 hours after To the Funaral Dira completely filled in b	Medical (	29a. Certifier 1 (X Certifying Phys (Chack only 2   Medical Examin	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, death	place, ar	nd due to the	cause(s) date and	and mani place, an	ner as sta d due to	ated. the cause(s)	)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	C . N.		29c.	License	number			29d. Dat	e signed (	Month, L	Day, Year)		
			H. J. H XX	LAN		D44	4104				Augus	t 19	, 20	04		
	4		30. Name and address of person who co A.Z. Hegazi, 46B Th				derio	ck, Ma	ary1a	and 2	1702					
ţ:	Sta	200	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature				-							
	Registr	ar	SEP 0 7 2004	General	4 1		,									

DHMH 17 Rev 1/2001

			State of Maryland / De	epartment of Health and Mertificate of Death		16 28235
	* Physici /Medic Examir	al	DOUGLAS JOSEPH STIMSON      Aa. Facility Name (If not institution, give street and number)  FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK		
	Funeral Director		5. Social Security Number  538-30-2208  0. Sex  1  M 2 F  7. Age (In yrs. last birthd)  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex  1  Sex	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 11, 1924	9. Birthplace (State or Foreign Country) Washington
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show lical Examires and the motified at	i Director	10a. State 10b. County 10c. City, Town o	r Location sville 10f. Zip Code 21773	10g. Citizen of V	10d. Inside City Limits 1 □ Yes 2√√ No What Country?
21215-0036	72 hours after death with the Marylar natural', or Items 23a or 28a-f show Ites Exandres coust be neithed at	ted by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:    Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Speci	ecify Yes or No- Rican, etc.) 14. Rac Blac Specify	ce - American Indian, ck, White, etc.
	e filed within 7: If Hygiene. othar than "n	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work. e. DO NOT use retired)  Personal Investor	Privat	e Investments
Maryland	should be fi and Mental H s marked ot umatic evan	To Be	Thomas Douglas Stimson	Emma  ailing Address (Street and Number or Rura	e (First, Middle, Maiden Suman  Baillargeon  al Route Number, City or Town,	L
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "naturany injury or other traumatic event, the Madical ARCS.		Charles D. Stimson/Son 762  20a. Method of Disposition  1 Burial 2 Kermation 3 Removal from State 20b. Place of Disposition cemetery, 6	7 Huntmaster Lane,	McLean, Virgin 20c. Location 0/2004 Smithsb	cia, 22102 City or Town, State ourg, Maryland East Church Street
3760,	/Medical Examiner whysician and prial-transit the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Each of the diffing Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		archien	Approximate Interval Between Onset and Death 2 Day 5
P.O. Box 68	death certific e attending p od for use as l	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Dat	e of delivery nth Day Year
Records, P	The law requires that the de ate has been signed by the a page 2 should be detached	Completed by P	Part II. Dther significant conditions contributing to death but not resulting in the Pylmonay Fibrosis  Diabetos MP/11ty 5	underlying cause given in Part I.	1 ☐ Yes 2 No 24a. Was an 24b. V	ribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of
Vital R	ysician: The s certificate h director, page	To Be Con	25. Was as referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpal	26. Place of Death	performed? d 1 ☐ Yes 2 No 1	death?
Division of Vital	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification: 7	27. Manner of Death    Natural   5	e of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurr 28f. Location (Street and Number City or Town, State)	ed
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical C	29a. Certifier (Check on one)  Certifying Physician: To the best of my knowledge, de (Check on one)  Certifying Physician: To the basis of examination and/or and manner stated.	29c. License number	ed at the time, date and place, a	and due to the cause(s)  I (Month, Day, Year)
i	30		30. Name and address of person who completed cause of death (Item 23a) (Type	m D51643	8/48 mp x1702	104
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 0 7 2004  SEP 0 7 2004	Dr Frederick	mp 21702	

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrer	State of Ma	ryland / Depa	artment of rtificate o		and Mental	Hygie Reg.	20	04	282	236
	Physic	an	Decedent's Name (First, Middle, Last	י				2. Oate Mont	of Death th	Dav	Year	3. Time o	of Death
	/Medi		Bertha Ju					Aug	ust	26 2	004	1320	) P M
	Examir	ner	4a. Facility Name (If not institution, give				n, or Location o	f Death		4c. County			
	F		Laurelwood Care ( 5. Social Security Number 6. Se		(In yrs. last birthday)	Elkto		24 Hrs.   8 Date	of Righ	Cec		lana (Ctata	F
	Funeral Director			M 2XF 86		Months Day		Min. (Mon. DEC	of Birth th, Day, Ye.	ar) .917		lace (State htry) yland	
	P.		Usual Residence of Decedent					IDEC	10/ 1	<u> </u>	Har	/ Lanu	
	arylar show	-	10a. State 10b. County		10c. City, Town or Lo	ocation					1	Od. Inside C	1
	he M	Funeral Director	Maryland Cecil  10e. Street and Number		Elkton	1							s 2 ⊠ No
	with a or 3	급				10f. Zip Code				Citizen of V			
	leath	era	104 Windsor Drive	12. Was Decedent E	ver in U.S. 13	219:		in? (Specify Ves		nited	State - Americ		
က္	r Her	들	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💆 N	0			gin? (Specify Yes , Puerto Rican, et	c.)		ck, White,		
03	ral', c	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠N	No Specify:			Specify	Whi	.te	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Hems 23a or 28a-1 show int, It a Midical Exartirar must be nuffied at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occ	ne during most	of working	16b.	Kind of Bu	usiness/Inc	lustry	
121	within and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	I di	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use ret	ired)	,					
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ary	should and Men s marka umatic	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Stre		r or Rural Route N		or Town,	State, Zip	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hyglene. Item 27 Is markad other than "natural", or Items 23a or 28a-1 show ther traumatic avant. If a Miscles Examiner must be n		Kathleen Skozypi	c/Daughter	1			Elkton,					
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Computal from Ctata	20b. Place of Dispo cemetery, free Immacula	sition (Name of		Date eptember	20c.	Location -			
Ē	Pages ment of l ant: If it		'4 □Donation 5 □ Other (Specify)	Heliloval Ilom State	Conception	on Cemet	tery   1	, 2004	Ch	errv	Hill	Mary	land
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	ee	22 H:	Name and Add	dress of Facility	Funerals	, P.A				
	0.01 = 8 01		Donal S.	Huko		03 W. St	<u>cockton</u>	Street,	Elkt	on, M	aryla		
		9	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	ine death. Do not ent e.	er the mode of d	lying, such as c	ardiac or respirat	ory arrest,			Approximation and Interval Bell Onset and	te tween Death
層	Pnysician /Medical		disease or condition resulting in death)		nentia							-10	Gear
	Examiner				consequence of):	CVA						300	a.c
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):	C V / 1	7-7-9-1 E				-	500	7)
	nd nd Iransi	Examiner	triat initiated events	, FSJ	ential	Hyper	rtens	ion				304.	ears
90,	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a	consequence of):	1.1							
8760,	physic the p	dicai		d									
9 x	eath certific attending p for use as t	Physician/Me	IF FEMALE:	3c. If yes, outcome o	f oregnancy					221 D			
Box	death a atter	ciar	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 Live birth 2 4 Pregnant at t	! ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)				23d. Date Mor	e of deliver nth	•	Year
0	to the de by the tached	hys	9 Unknown	9□ Unknown									
S, D	es tha igned be del	by P	Part II. Other significant conditions con	ntributing to death but	not resulting in the ur	nderlying cause	given in Part I.	23e.	Did tobacco	use contr	ribute to the	acause of c	death?
ord	w require been si should b		Jysphay14	Aspila	ation Pre	umonia	9	_	1 🗌 Yes	211No	3 Proba	ıbly 4 🗀 l	Unknown
Vital Records,	law r nasbé s2sh	Completed	Depression						Was an autopsy	24b. V	Vere autop	sy findings	available
E H		Con							performed?	d	feath?	2 No	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:				of Death (Check o	only one)				
of		. To	1 ☐ Yes 2 Ø No 27. Manper of Death	1 Inpatien 28a. Date of Injury		t 3 DOA 28c. inj		sing Home 5	Residence				
on	Attanding I r death. ector: After by the funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	W	ork? □Yes 2 □ N		IIDO IIOW III	ary occurre	eu		
Division	al or Attandii after death. I Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, farm, stre (Specify)			28f. Locati	ion (Street	and Numbe	er or Rural	Route Num	ıber,
Ö	tal or s afte al Dire	Certification:	4   Hollidge	building, etc.	(Specity)			City o	r Town, Sta	te)			
	To tha Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physics (Check only 2 Medical Examin	sician: To the best of	my knowledge, death	occurred at the	time, date and	place, and due to	the cause(	s) and mar	nner as sta	ted.	-
	To tha twithin 2. To the f	Medical		and manner state	ed.			TOOGGITEG ALTINE L					·/
	Z × C S		29b. Signature and title of certifier		10		nse number	2		ate signed			/ 4
7			20 Name and district	mplated a state of	ath (Item 23a) (Type, I	レフ	1166	)	AU	gust	21	, 2009	†
	2	12	A A I L TE I/A A	avang MD	23a) (Type, I	Cathed	1015+	3 . Elkt	Din 1	40	7/97	. 1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Hegistra	S Separation	on I vich			- 11 1		0 1 1 6	1	-
D.	Registr	ar	SEP 0 7	2004 > 3	energy		4.4						

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 27 AUGUST 2004 Rosalie Rollins Swann 8:17 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Marys Leonardtown St. Mary's Hospital ff Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min Hours 1 ☐ M 2 🂢 F 96 Yrs. January 28, 1908 Maryland Director 217-74-6466 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, I'le Medical Examérat must be reditied at 1 ☐ Yes 2 ☑ No Directo Mechanicsville Maryland Charles the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 9835 North Ryceville Road USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) nd Mental Hygiene. marked other than 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Hy importent: If Item 27 is marked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be David Rollins Rachel Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Samuel Swann / Son 9935 North Ryceville Road, Mechanicsville, Maryland 20659 August 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Episcopal Cemetery 31, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Newport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Tichael Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate-Cause (Final disease or condition resulting in death) Sepm **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. À 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Tes 2 No 1 Tes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SC Gaby D54346 30 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAH ASSOC HOLLYWOOD 20636 CHANDRA SAJJA 32. Registrar's Signature 31. Date filed (Month, Day, Year, State AUG 8 0 2004 1909000 Registrar

ROSALIE

Richard Schmadebech 8/18/04 1350

104 13				State of M	andano	1 / Dono	ertmont of	Hoalth	and Mont	lal Hygio	no	<b>).</b>
		1 - For State Registrar		State of W	ai ylaiic		tificate of		)	Reg.	200L	28239
Physic	sian	Decedent's Name (	First, Middle, Last	)						ate of Death Nonth	Day Yea	
/Med		Richard I								gust 18		1:50 p
Exam	iner	4a. Facility Name (If n	ot institution, give	street and number)			4b. City, Town,	or Location	of Death		4c. County of D	eath
		Suburban					Bethes If Under 1 Yea		r 24 Hrs.   8, D	to (Pint	Montgo	
Funera Directo		5. Social Security Nun 220-34-265	51 1 <u>0</u>	X 7. AG	je (In yrs. la	Yrs.	Months Day:		Min. De	ate of Birth Month, Day, Ye	1938 W	Birthplace (State or For Country) ISCONSIN
and and		Usual Residence of D	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Lir
f sho	5	Maryland	Prince G	eorge's			College	Park				1 \ Yes 2 □
28a	Je C	10e. Street and Numb		eorge 3			10f. Zip Code	laik		10g.	Citizen of What	Country?
39 0	<u> </u>	3400 Duke	Stroot					20740		ī	J.S.A.	
ms 2	Jera	11. Marital Status	Bereet	12. Was Decedent	Ever in U.S	6. 13. V	Was Decedent of f Yes, specify Cu		rigin? (Specify )		14. Race - A	merican Indian,
uges I and a Should be liled within 7.2 hours arier bean with the maryland of the aith and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, Ite Madical Executer must be netified as	Completed by Funeral Director	1 Never Married		Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:			r Yes, specify Cu t ☐ Yes 2 $\overline{X}$ No			i, etc.)	Black, W Specify:	White, etc.
atura	ted	10 1	5. Decedent's Edu	cation		16a. Deced	lent's Usual Occi	pation		16b	. Kind of Busine	ss/Industry
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snould be liled within and Mental Hygiene.  marked other than "umatic evant, Ire Max	Be	17. Father's Name (F	irst, Middle, Last)					18. Moth	er's Name (Firs	t, Middle, Maid	den Sumame)	
ond Menta marked umatic e	To	Louis F. S	Schmadebe	ck				Mar	ie Hart	1		
and h	100	19a. Informant's Nam	ne/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Stree	at and Numb	er or Rural Rou	ite Number, Cit	ty or Town, State	e, Zip Code)
alth 27 I		Annette I	. Schmad	.ebeck - V	Vife	3400	Duke St	reet,	Colleg	e Park,	Mary1a	nd 20740
item oth		20a. Method of Dispo			1 00	ace of Dispo	sition (Name of natory or other pi	ace)	Date	20c.	. Location - City	or Town, State
int: If			Other (Specify)	Removal from State	Oak	wood (	Cemetery	A	Aug. 24,	2004 Ве	eaver Da	am, WI
Department of Health amount of Health amount or other tra		21. Signature of Fune	eral Service Lipone	7		22	. Name and Add	ress of Facil	ity Gasch	's Fune	eral Hom	e, P.A.
Impo any ir		Lali	It C	1 ay			739 Balt					
hysiciar /Medica xaminei		23a. art1 Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	inal	Septic Due to (or as	Shock a conseque	ence of):	arcinoma		s cardiac or resp	orratory arrest,		Approximate Interval Betwee Onset and Dear I Week  Less Than 6 Months
n and al-transit	Examiner	Sequentially list condif any, leading to imm cause. Enter Unuerly Cause (Disease or in that initiated events resulting in death) La		Due to (or as	a consequ	ence of):						o Honens
oeatil celtilitate be executed e attending physician and of for use as the burial-transit	a			d								
ding se as	/Me	IF FEMALE:		3c. If yes, outcome	of pregnan	icv					02d Date of	4-15
institute destill be under the background of by the attending physician and detached for use as the burial-transit	Physician/Medic	23b. Was decedent p in the past 12 m 1 Yes 2 U 9 Unknown	onths?	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3□	Ectopic pregnan Other (specify)	су			23d. Date of a Month	Day Year
aw requires that the as been signed by th 2 should be detache		Part II. Other signific	ant conditions co	ntributing to death t	out not resul	lting in the ur	nderlying cause g	iven in Part	l 2	3e. Did tobacc	o use contribute	to the cause of death
sign d be	d b	Non Hodgk	cins Lym	phoma						1 🗆 Yes	2 □ No 3 □	Probably 4 ∑Unkr
been si	ete	Hypertens	ion	-						4a. Was an	24h Wasa	autopsy findings avai
ate h page	Completed by	Hypertens	51011							autopsy performed	? prior t death	to completion of cause
certificate	Be	25. Was case referre examiner?		Inneibel:					e of Death (Che	eck only one)		
this o	2	1 ☐ Yes 2 🔀 N	0			R/Outpatien	t 3 DOA				6 □Other (S	oecify)
Hospital Particular Securities of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the secon				28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Ing W M 1 [	ury at ork? □Yes 2□		Describe how in	njury occurred	
after de Director d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	jury - At hor tc. <i>(Specify)</i>		eet, factory, office	•	28f. L	ocation (Street lity or Town, St	and Number or ate)	Rural Route Number,
S E W	edicai (	29a. Certifier 1 (Check only 2 one)	X Certifying Phy ☐ Medical Exami	sician: To the best ner: On the basis of and manner st	of examination	rledge, death on and/or inv	occurred at the restigation, in my	time, date ar opinion, dea	nd place, and di ath occurred at	ue to the cause the time, date a	e(s) and manner and place, and d	as stated. lue to the cause(s)
24 hours he Funaral	40	OOk Cinneture and til	he of certifier	1			29c. Licer	nse number		29d. I	Date signed (Mo	onth, Day, Year)
within 24 hours To the Funaral	Me	29b. Signature and the										
To the Propriet or Attending Frigstoans, within 24 hours after death.  To the Funaral Director: After this certification completely filled in by the funeral director.	Me	29b. Signature and th	1 11	/	00		İ	D359	96	Au	igust 18	, 2004
o the hospital within 24 hours of To the Funaral completely filled	Me	30. Name and address										

DHMH 17 Rev 1/2001

			1- For State of Maryland / De	partment of Health		al Hygien	0.001	2021.0
			Negistrar  1. Decedent's Name (First, Middle, Last)		2. Da	te of Death		3. Time of Death
	Physici		Ricardo Alphonso Stevens			ig. 17,	2004 Year	3:00p M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death		c. County of Deat	
			2170 Alice Avenue	Oxon Hill		]	Prince G	eorge
	Funeral		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birthd	Months Days Hours	rs Min (M	te of Birth onth, Day, Yea	() (Co	hplace (State or Foreign untry)
	Director			·	Ar	or.8,196		nington,DC
	DU 3		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or	Location				10d. Inside City Limits
	show	ō						1XYes 2 □ No
	28a-1	Director	Maryland   Prince George   Camp Spr	10f. Zip Code		10g C	itizen of What Co	untry?
	with sa or		5506 Chesterfield Drive	20748			ited Sta	
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show diest Examinal must be multibed at	Funeral		Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify Y		14. Race - Ame	
10	r Iten	Fun	Never Married 2 Married 1 Yes 2 XNo			etc.)	Black, White	
93	ali, o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes X☐ No Speci	cify:		Specify: B	Lack
21215-0036	72 ho	Completed by	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	nost of working	16b.	Kind of Business/	Industry
21	within ene. than "r	lg l	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	noot or manning			
	ed wi ygien rer th	Co	12 Che					sician Servi
pu	tal H d ott	Be	17. Father's Name (First, Middle, Last)		other's Name (First		*	
Maryland	ges I and 2 should be filed within 72 hours after death with the Maryla it of Health and Mantal Hygiens in artural; or items 23a or 28a-1 show if item 27 is marked other than "natural; or items 23a or 28a-1 show or other traumatic event, the Medical Examinating as I be nutilized at	ျ	Eugene Stevens		eraldine	Evans		
Nar	12 sh n and 7 Is n			ailing Address (Street and Nun				(ip Code)
e,	1 and 1ealti sm 2 ther t			O Alice Ave.,	UXON H1		20745 Location - City or	Town State
Baltimore,	in of h		1 Burial 2 Cremation 3 Removal from State	crematory or other place)			1	
ţ	t. Pa rtmer rtant rjury			litan Cremator	1			Virginia
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Fa Alexander S. P 5538 Marlboro	Pope Fune Pike For	ral Hom estvill	e, Md. 2	0747
			23a. Part1; Etter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such	as cardiac or resp	ratory arrest,		Approximate Interval Batween
	Physician		Immediate Cause (Final disease or condition	TIO CANO	58			Onset and Death 6 MONTUS
	/Medical		resulting in death)  Due to (or as a consequence of):	cc CANC				O to(Dio(It2
	Examiner		Sequentially list conditions b.					
	p	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury					
	ecute and -trans	cam	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):					
8760,	cian course	<u>E</u>	Due to (or as a consequence of).					
87	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical	d					
9 x	leath certific attending p	0	IF FEMALE: 23c. If yes, outcome of pregnancy				22d Date of doll	uon/
Вох	atten for u	Physician/M	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli Month	Day Year
o.	the di	yslo	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	3 🗆 Other (apocaly)				
ص.	res that the de igned by the a be detached t	/Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pa	art I. 23	3e. Did tobacco	use contribute to	the cause of death?
sp.	uires sigr Id be	d by				1 Tes	2 □ No 3 □ Pro	obably 4 Unknown
Records,	w require been si should l	Completed			24	ta. Wasan	24b. Were au	topsy findings available
Re	ician: The lav certificate has ector, page 2	m d m				autopsy performed?	prior to d	completion of cause of
_	ysician: The is certificate ha director, page		25. Was case referred to medical	ne Bl	1 [ lace of Death (Che		lo 1 🗆 Yes	2 No
Ë	Physician: this certific ral director,	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa		Nursing Home 5		6 (VOther (Spec	Mother's
of	유 분 교		27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at		escribe how inj		nésidence
ion	Attending r death. actor: After y the fune	atlo	1∠Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	ry Work? M 1 ☐ Yes 2	! □No			
Division of	Attendi r death. actor: A by the fu	if	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		cation (Street a		ral Route Number,
Ō	alor safte	Certification;	building, etc. (Specify)			ly or rown, sta	(6)	
	To the Hospital or Attent within 24 hours after death To tha Funeral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, do not be best of examination and/o and manner stated.	eath occurred at the time, date r investigation, in my opinion, c	and place, and du death occurred at t	e to the cause( he time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of pertifier	29c. License numbe	er	29d. D	ate signed (Month	n, Day, Year)
)	. 750	1	Jan Thomas up	D0061	083	Au	GUST 19	1,2004
no	(11)		30. Name and address of the on who completed cause of death (Item 23a) (Ty					
U'	(1)		Paul M. Thambi, M.D., 9707 Medical	Center Drive,	Rockvill	e, MD	20850	
	Sta Regist		31. Date filed (Month, Day, Year)  AUG 2 0 2004  Registrar's Signature	north				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylar		ificate of			Reg. No.	) 4	28211
Physician /Medical	Decedent's Name (First, Middle, Last     ETHEL WILHEL	MINA SCHAEFEF	2			2. Date of De Month August	_ Day	4 ^{Year}	2:15PM
xaminer	4a Facility Name (If not institution, give Brooke Grove Reha				4b. City, Town, or				
neral ector	Social Security Number     6. Se		last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir	Montgo	9. Birthp Coun	lace (State or Foreig try) h. D.C.
	Usual Residence of Decedent					restant	7 0/1510		
_	10a. State 10b. County		ty, Town or Loca					1	0d. Inside City Limit 1 ☑ Yes 2 ☐ N
ecto	MD Montgomer  10e. Street and Number	y Sar	ndy Spr	10f. Zip Code			10g. Citizen of	Mile at Cause	
niner must be notified Funeral Director	18131 Slade School	l Road		20860			USA	vviiat Court	uyr
any injury or other traumatic event. The Madical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of Mes, specify Cub Yes, specify Cub ☐ Yes 2 🔼 No	Hispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	Specif	ce - Americ ck, White, White	
Completed by	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	16a. Decede (Give ki	nt's Usual Occup ind of work done O NOT use retire	pation during most of wo	orking	16b. Kind of B	usiness/Inc	lustry
Comp	Elementary/Secondary (0-12)  11  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		maker		me (First, Middle	own ho		
To Be	Thomas R. Dedge					Padden	, Maiden Suman	116)	
•	19a. Informant's Name/Relationship (Ty		_		and Number or R		-	•	-
	Jean Mills/Daught	20h F	Place of Disposi	tion (Name of	r Court,	Sliver	Spring, I		
	1 ☐ Burial 2 ☐XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Me1		itory or other pla tan Cren		8/18/04		-	
once.	21. Signature of Funeral Service License	Boll		Name and Addre	^{ess of Facility} O Vania Ave.	edar Hill "Suitland,		ame,In	c.
ian ical	23a. Parth. Enter the disease, or complete hock, or heart failure. List only or Immediate Cause (Final disease or condition			the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
ner	resulting in death)	Cardiomypat Due to (	ny or as a consequ	ence of):				-	years
edical Examiner	Sequentially list conditions,	. Coronary ar	tery di	sease				7	years
alEx	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Essential h						7	years
	resulting in death) Last		r as a conseque	900001):					
iciar	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	erlying cause giv	ven in Part I	23b Did	tobacco use co	ntribute to	the cause of death
Phys				,g g					ably 4 ☐ Unknow
page 2 should be detached for use a:  Completed by Physician/Me						24a. Was perfo	an autopsy rmed?	ava	re autopsy findings ilable prior to npletion of cause leath?
Con						131	Yas 2 XNo	- 310	Yes 2∐No
Be Be	25. Was case referred to medical examiner?	lospital:		Oth		ath Check only o			
completely filled in by the funeral director, page.  Medical CertIfIcation: To Be Comp	1  Yes 2  XNo	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injui	4 km innising i	dome 5 ☐ Resident 28d. Describe I	dence 6 □Oth now injury occurr		)
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	t, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rurai	Route Number,
dical C	29a Cartifier (Check only one) 1 Cartifying Physical Examination	Iction: To the best of my knower: On the basis of examina and manner stated.	wladge death o tion and/or inve	ocurred at the tile stigation, in my o	ne, date and plan. pinion, death occi	and due to the urred at the time,	name(e) and ma date and place,	and due to	the cause(s)
No.	29b. Signature and title of certifier	— M		29c. Licens			29d. Date signe		Day, Year)
	30. Name and address of person who co								
	Burt I. Feldman,			e World	Blvd. S	ilver Sp	ring,MD	20906	<u> </u>
State Registrar	31. Date filed (Month, Day, Year)  AUG 2 0 2004	32 Registrar's Signa	ature for	<i>.</i> •					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19, 2004 Raymond Melbert Schluter August 11:10PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Prince Georges Medical Center Cheverly 7. Age (In yrs. last birthday) **Funeral** 1 x M 2 □ F 67 457-56-5446 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Itams 23e or 28e-f ehow the Modical Exemples must be notified at 1 →Yes 2 No Bowie Director Prince Georges Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20715 12402 Kemmerton Lane death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural; or Itan any injury or other traumatic event, the Medical Examinations. 1 ⊠Yes 2 □ No If Yes, Give 1954 Year or Dates: 1059 1 Never Married 2 Married Specify: White 1 Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 ρ 3 Widowed 4 X Divorced 1958 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Gov't. Computer engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond Schluter Melba Schwab ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 7 2 6 8 19a. Informant's Name/Relationship (Type, Print) Venus D. Payne-daughter 278 Hawbaker Ave., Waynesboro, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 08-24-04 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Md. Veterans Cemetery • 4 □ Donation 5 □ Other (Specify) Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or a consequence of Examiner 50 Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit meame that initiated events resulting in death) Last Due to or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dr. Kathern IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed þ **pe** 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe has certificate 1 ☐ Yes 2 ☑ No Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 / Inpatient 2 ER/Outpatient 3 DOA ဥ this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 XNatural 2 ☐ Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 0 - 312 larker dep 22///

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address f person

7 HOMAS

31. Date filed (Month, Day, Year)

AUG

23

2004

d cause of death (Item 23a) (Type, Print) flore

Registrar's Signature

04 - 5345B.K.S JACOB J. STERGIOU

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	, 0. 511		1 - State Registrar	State of Maryland		artment of H tificate of L		Mental Hy	giene Reg.NO ∩ ∩ i	. 20212
	Physici	_	1. Decedent's Name (First, Middle, Lasi	Jacob Josep	h St	ergiou		2. Date of De Month AUG.	ath -	3. Time of Death 4 0105 A
	/Medic Examin	_	4a. Facility Name (If not institution, give PRINCE GEORGES H			4b. City, Town, or CHEVER			4c. County of	
	Funeral Director		5. Social Security Number 6. Se 215-21-6133	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir Mar.	th year) 26,1988	Birthplace (State or Foreign Country) Maryland
	Maryland 9-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Calve	ert No		cation Beach				10d. Inside City Limits 11∑ Yes 2 □ No
	with the 3e or 28e	I Director	10e. Street and Number 9356 Sea Oat	Court	-	10f. Zip Code 2 0	714		10g. Citizen of Wha	at Country?
5-0036	hours after death with the Maryland kurel', or Items 23e or 28e-f ehow Executes frout be notified at	by Funeral	11. Marital Status  1    XNever Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cubar □ Yes 2 🕱 No		Specify Yes or No to Rican, etc.)	14. Race - Black,	American Indian, White, etc. White
0-61217	filed within 72 hours Hygiene. ther then "neturel", ont, I ize Madical Era	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give . life. [	lent's Usual Occupa kind of work done d DO NOT use retired, I dent	ation luring most of wo )	orking	16b. Kind of Busin	ness/Industry
yland z	0 7 5	To Be C	17. Father's Name (First, Middle, Last)	iko D. Stergi	ou,	Sr.		-	Maiden Sumame) L. Louia	
Mary	id 2 shouth and National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National National Natio		19a. Informant's Name/Relationship (T Karen E. Louis						er, City or Town, Sta h Beach	ate, Zip Code) , Md. 20714
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked eny injury or other treumetic e and ing.		20a. Method of Disposition  1 XBurial 2 Cremation 3 1  4 Donation 5 Other (Specify	20b. Plac	e of Dispos	sition (Name of natory or other place Mem. G	9) 08-	23-04	20c. Location - Cit	
Balti	permit. Departm Importer eny inju		21. Signature of Funeral Service License	<u> </u>		Name and Addres		Beall F in Hwy.	uneral	Home , Md. 20715
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. HULTIPLE  Due to (or as a consequent)	NNA		g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
8/60,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Laus (1.56.5 fr. ju.) that initiated events resulting in death) Last	b. Due to (or as a consequer  c. Due to (or as a consequer  d.	,					
O. Box 6	death certif e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date o Month	of delivery Day Year
ecords, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the ur	nderlying cause give	n in Part I.			ite to the cause of death?  Probably 4 □Unknown
T	The law ate has b page 2 sl	Completed						24a. Was auto perfo 1 \( \text{Yes}	osy prio ormed? dear	re autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
от Vital	d S	To Be	25. Was case referred to medical examiner? 11 Yes 2 No	Hospital: 1 ☐ Inpatient	VOutpatien	t 3 DOA Othe		ath <i>(Check only c</i> Home 5□ Resi	one) dence 6 □Other(	'Specify)
DIVISION O	ling After fune	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	(Month, Day Year) 8 (18   04	3b. Time of Injury		at ? ∕es 2⊠No	CAR INVO	HOW INJURY OCCURRED	COLLISION
2	o after		4 Homicide determined	building, etc. (Specify)				PWH POIN	VI, State)	or Rural Route Number,
	승규들은	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	vsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim restigation, in my op	e, date and plac iinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated.  due to the cause(s)
	To the I within 2 To the I complet	Ň	29b. Signature and title of certifier	`		29c. License	number .M.E		29d. Date signed (A AUG. 19	Month, Day, Year) 9, 2004
PA	R 15)	)	30. Name and address of person who c	ompleted cause of death (Item 23	3a) (Type, 1 11 Pe	Print) nn Street	, Balti	nore, Ma	ryland 21	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 3 2004	2. Registrar's Signature		B)				

DHMH 17 Rev 1/2001

Director To the Hospital o within 24 hours aft To the Funeral Di

30. Name and address of person who completed a se of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

THEODORE M. KI 31. Date filed (Month, Day, Year) AUG 2 3 2004

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 19, 2004

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 15 2004 11:00PMM JANE W. SIMMONS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2X F OCT 12 1915 Director 488-01-0100 88 MISSOURI Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or liem" any injury or other treumatic event 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director MD TALBOT WITTMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8464 CUMMINGS RD 21676 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 SECRETARY HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN ORVILLE WATSON ELLA WASSERFALL ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT J. SIMMONS/SON 9400 NEW ROAD, MCDANIEL MD 21647 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 8-17-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 ST CHOL MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final testinal 2 4 95 Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ pertension 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes **Division of Vital** or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🗹 No r this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 447587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schilling Cynwood Dr Faston Mb 21601 USSELL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

ORIGINAL

		•	For State Registrar	State	of Maryla		artment of H rtificate of L			iene	nnl	2821.	6
ı			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	th	(Year)	3. Time of Dea	
	Physicia /Medic		FRANCES E.	STEVENSO	N				A'ug.	16	200	4 0923	AM
	Examin		4a. Facility Name (If not institution Memor	n give street and r ial Hos	pital		4b. City, Town, or Easto	Location of Death		4c. Co	albot		
	Funeral Director		5. Social Security Number 227–22–2366	6. Sex 1 □ M 2 F	7. Age (In ye	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day MAY 3 I	1 ^Y 9 ² 1 ⁾ 5	9. Birth VA	place (State or Foi intry)	reign
7	pu ,		Usual Residence of Decedent  10a. State 10b. County		100	City, Town or Lo	postion					10d. Inside City Lin	mita
	shov	5		TALBOT	100.	EAST						1 XYes 2 □	
	the N	Director	10e. Street and Number	IALDOI		LEAST	10f. Zip Code	-	1	0g. Citize	n of What Cou	intry?	
	3a or		610 GOLDSBOROU	GH ST				601			USA		
	deatl	Funeral	11. Marital Status	12. Was De	ecedent Ever in Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecity Yes or No-	14	Race - Amer Black, White		
213-0036	be filed within 72 hours after death with the Maryland hal Hygiene. id other than "naturel", or Items 23a or 28a-f show event, in Madical Exameration must be political at	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ X Widowed 4 ☐ Divorced	ried 1 Tes	s 2X No	1	1 ☐ Yes 2 XNo	Specify:	riioari, etc.,	Sį		HITE	
2	72 ho	eted	15. Deceder (Specify only highe	t's Education	d)	(Give	dent's Usual Occupa	durina most of work	ina	16b. Kind	of Business/l	ndustry	
V	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired	)	9	OT	DI HOM		
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yland	ild be f lental l ked of ic ever	o Be	THOMAS JOSEPH						RY E. SPR		,		
	s 1 and 2 should be f Health and Mental item 27 is marked other traumetic ev	ဥ	19a. Informant's Name/Relations			19b. Maili	ng Address (Street a					p Code)	
Z	7.2 g g		FLORENCE E. BA	LL/PER R	EP	61	O GOLDSBO	ROUGH ST	EASTON,	MD 2	21601		
e,	of Hea of Hea litem		20a. Method of Disposition 1 Burial 2 XCremation		200	p. Place of Dispo cemetery, crei	sition (Name of natory or other place		Date	20c. Loca	tion - City or T	own, State	
Ĕ	Page ment ant: th		'4 □Donation 5 □ Other (5			HESAPEA	KE CREMAT	ION CTR 8	3-18-200	4 STI	EVENSVI	LLE, MD	
baltimore,	permit Pages 1 Department of H Imporant: If ite any injury or ot ance.		21. Signature of Funeral Service	Licensee II	CFS	F	2. Name and Addres ELLOWS, H OO S. HAR	ELFENBEI				HOME PA	
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	Physician		Immediate Cause (Final disease or condition	. 4	BOOT	FAI	UME					Onset and Death	h S
	/Medical		resulting in death)	Due t	to (or as a cons	sequence of):		ا ود	1.6				
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	per jist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due	to (or as a cons	sequence or):						of 1	
	cate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c	to (or as a cons	sequence of):							
8/60	e be e	dical		L d.									
Q													
EOX	death certifi e attending p ed for use as	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ► No	1 Liv	outcome of pre- e birth 2 Fe egnant at time of	etal death 3	Ectopic pregnancy Other (specify)			230	d. Date of deliving Month	ery Day Year	
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rds,	law requires that the der as been signed by the a 2 should be detached f	by	Part II. Other significant conditi	ons contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.				the cause of death bably 4 □Unkn	
ecord	aw re	Completed		ANG	MIA				24a. Was a autops		24b. Were aut	opsy findings avail	iable
r	The ate h page	Com							perform	ned?	death? 1 ☐ Yes		
VItal	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medica examiner?					26. Place of Deat					
10	Physi this c al dire	္	1 ☐ Yes 2 No			ER/Outpatier		4 Nursing Ho	ome 5 Reside			fy)	
	ffe and	tion	27. Manner of Death  1 Natural 5 Pendi	ng (M gation	te of Injury onth, Day Year	28b. Time o Injury	Work	Yes 2 □ No	28d. Describe ho	ow injury c	occurred		
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could	not be 28e. Pla	ce of Injury - A	t home, farm, st	reet, factory, office		28f. Location (St	reet and f	Number or Rui	al Route Number,	
É	s after al Dire	Certification:	4 Homicide	bu	ilding, etc. (Spe	ecify)			City or Town	n, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical (		Examiner: On the			h occurred at the tim vestigation, in my op						
	To th withir To th comp	Me	29b. Signature and title of certific	" prof		>	29c. License				signed (Month	-	
						7)		00025	>	8-	- 16 -	04	
			30. Name and address of person	, 609	DUTO	= HMM	VS LAW	巨, 巨力:	STON, 1	70,	2160	>	
	Sta Registi		31. Date filed (Month, Day Year AUG 19	MOH S	. Registrar's Si	gnature Acc	(A)	•		'			
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** HERBERT ROLAND SHOCKLEY, JR. 08 15 2004 12:25 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 25495 OCEAN GATEWAY MARDELA WICOMICO If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1)♥ M 2□ F Yrs. Director 219-60-1051 53 11-26-1950 SALISBURY, Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at ty□Yes 2□No **Funeral Directon** WICOMICO MARDELA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 25495 OCEAN GATEWAY 21837 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 INSURANCE AGENT INSURANCE COMPANY permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event size. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HERBERT R. SHOCKLEY, SR. ELVA IRENE LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVONNE SHOCKLEY - SPOUSE 25495 OCEAN GATEWAY, MARDELA, MD. 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM.GDNS. 08-19-2004 HEBRON, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Puneral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure last only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENIAL CETT CAMER 8 4ks. Metasta ti /Medical Due to (or as a consequence of) **Examiner** Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical esn esn IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, should be 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an autopsy has certificate g No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No ٩ Chis After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No s after death.
I Director: A death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral L filled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) prulle 732014 2/16/04 Maly 4 30. Name and address of person who compfeted cause of death (ftem 23a) (Type, Print) 106 MILFOVI) St SOUB SAIISBULY CONDITION MOONBEA AUG 1 6 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	/larylan		artmen				lental H	ygien Reg. N	200	1,	2021.0
			Decedent's Name (First, Middle	, Last)							2. Date of D	eath		0.0	3. Time of Death_
	Physici		Bernard	Maurice		Sp	arby				August.	11, 2	2004 `	Year	8:15 4
	/Medio Examin		4a. Fecility Name (If not institution		r)			Town, or	Location of	of Death			c. County of	f Death	
	_xa		8508 North Prong	Tane			Deli	nar					Wicom	ico	
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of B (Month, L March				lace (State or Foreign
	Director		387-24-6608	1 <b>X</b> M 2□ F	74	Yrs.					March 1	6, 19	930	•	onsin
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Limits
	l sho	ō													1 ☐ Yes 2 X No
	the h	ect	Maryland Wicom  10e. Street and Number	100	Der	.mar	10f. Zip	Code				10g. C	itizen of Wh	nat Cour	itry?
	with with	<u></u>	8508 North Pron	a Lane				.875					USA		, .
	ms 2:	Funeral Directo	11. Marital Status	12. Was Deceder	nt Ever in U	.S. 13.			spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race		
9	or ite	Ē	1 Never Married 2X Marri	Armed Force	Nο		it Yes, spe⊬ 1 □ Yes		n, Mexican Specify:		Hican, etc.)			White,	etc.
93	ours Final	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:		1 🗆 165	2 <u>0</u> 1 NO	эреспу.				Specify:	Wh	ite
21215-0036	72 h Inatu	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Usua kind of wo DO NOT u	al Occupa rk done d	ition <i>Juring most</i>	t of work	ing	16b.	Kind of Bus	iness/Ind	dustry
12	within	g E	Elementary/Secondary (0-12)	College (1-4d	r 5+)	Newsp						Pos	umont	Ent	erprise
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or Items 23a or 28a-f show int, the Medical Examinar must be rediffed at	ပိ	12 17. Father's Name (First, Middle, I			Mewsh	aper	F UDI			(First, Middl				erpribe
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Ž	shound M	-	19a. Informant's Name/Relationsh		ALDY	19b. Mailir	ng Address	(Street a			I Route Num			tate, Zip	
Ž	alth a		Holly Sparby	(wife)		8508	North	Pro	ong La	ane,	Delman	c, Ma	arylar	nd	21875
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a <u>once</u> .		20a. Method of Disposition	0 []D	20b. F	Place of Dispo	sition (Nar	ne of ther place	9)	C	Date	20c. l	_ocation - C	ity or To	wn, State
Ĕ	Page nent ent: It		1 ☐ Burial 2 【XCremation `4 ☐ Donation 5 ☐ Other (Sp		.0	isbury			!	aust	12, 200	4 Sa	lisbu	ry,	Maryland
ä	permit. Departr Import any inj		2). Signature of Funeral Service (	icensee		22 I	Name ar	d Addres	s of Facility	ăl H	ome Pro	ofes	sional	l As	sociation
<u> </u>	207			composed,		SP 5	501 Sr	ow F	Hill I	Road	, Salis	sbur			nd 21804
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the deat line.	h. Do not ent	ter the mod	e of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
Z	Priysician	6 1	Immediate Cause (Final disease or condition resulting in death)	_ a.		Au	اعلا	-EU	KEV	w (p	4				YEAR
	/Medical Examiner		resulting in dealing	Due to (or a	as a conseq	uence of):									
		-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a conseq	uence of):	-							-	
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>										-	
o,	exec an an	Exa	resulting in death) Last	c. Due to (or a	as a conseq	uence of):									
3760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	cal		d											
39	ing ph	Physiclan/Med	IF FEMALE:												
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	il death 3□	Ectopic p						23d. Date Monti		ry Day Year
o <u>.</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		leath 5∟	Other (sp	ecity)							,
٣.	res that the de signed by the a be detached f		Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco	use contrib	ute to th	e cause of death?
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Ве	he lav e has age 2 :	Completed	4,700	<del></del>	(	5					auto	ormed?	Drie	or to cor ath?	npletion of cause of
ta	an: T tiflicat tor, pa	Be C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes		0 1 1	Yes	2 No
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Ö	ng Ph ter th neral	T:uc	27. Manner of Death 1	28a. Date of Ir (Month, I	jury Day Year)	28b. Time of	f 2	8c. Injury Work	at		28d. Describe	how inju	ury occurred	1	
0	Attending or death. ector: After by the fune	atic	Ž ☐ Accident investig	ation			М		/es 2 □!	No _					
Division of Vital	or Att ter de irecte n by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and Zee Place of	Injury - At he etc. <i>(Specif</i>	ome, farm, str y)	eet, factory	, office			28f. Location City or To	(Street a own, Stai	nd Number 'e)	or Rura	Route Number,
	urs al		A	- Dharida - Fall I		-				4 - 1 - 2 - 2					
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier Certifyin (Check only 2 Medicel	g Physician: To the be Examiner: On the basis and manner	of examina	ition and/or in	n occurred vestigation	, in my op	e, date and inion, deat	th occurr	ed at the time	, date ar	s) and manr id place, an	d due to	ated. the cause(s)
	o the	Me	29b. Signature and Ale of certifier	11			290	. License	number			29d. Da	ate signed (	Month, i	Dey, Year)
	- > F O		> Kulk	Wy				034	557	-6			8/11	104	•
			30. Name and address of person	who completed cause o	f death (Iten	п 23а) (Туре,	Print)						_/_/		
2			ROWAD P.	RAVIT		40	56	0	اجسه	1	ala I	20	SALIS	5.	10815 CIM
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 2	2004 32. Regi	strar's Signa	ature &	de	ak							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-16-04/Wichigte of Maryland / Department of Health and Mental Hygiene 1- For O8-16-04/WIGHD
Amend#23b,c/PerPHYS,dq Certificate of Death Reg. No? 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician John Edward Smith, Sr. 0035 August 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Peninsula legional Medical Center

Social Societity Number 6. Sex 7. Age (In yrs. last birth SaliSbu/9 Year If Under 24 Hrs. WICOMICO 8. Date of Birth (Month, Day, Year 9-18-1918 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) 5. Social Security Number **Funeral** Min. 5 1 X M 2 □ F Months Days Hours DE. 222-07-2533 85 **Director** Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County ir then "natural", or Items 23a or 28e-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Director Sussex Delmar De. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19940 USA 900 Jones Terrace Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 公Yes 2 □ No 1944-14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 1946 White ģ 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Auto Dealership Office Manager Pages 1 and 2 should be filed venent of Health and Mental Hygicant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillie Belle Cordrey Smith Charles V. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John E. Smith, Jr. 10528 W. Snake Rd. Delmar, De. 19940 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or St. Stephens Cem. 8-13-04 Delmar, De. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dosoh 21. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Almerosclerotic heart disease **Physician** /Medical Due to (or as a consequence of) Examiner -Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine DM ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 32 DOA 1 Yes 2 No 28c. Injury at Work? To the Hospitel or Attending PI within 24 hours after death.
To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier arm D61495 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100E CARAOLI ST SALISBURY Mid. 21801 QINNO DHAR MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 1 6 2004

32. Registrar's Signature

			For State Registrer		State of	Marylan				lealth a Death		lental H	ygier Reg. I	201	04	282	50
			1. Decedent's Neme (First, Midd	le, Last)								2. Date of D Month		Day	Year	3. Time of	Death
	Physici /Medic		Dorothy	May	Sr	nith						August	: 13	, 200	)4	1:00	PMM
	Examir		4a. Fecility Name (If not institution	n, give str	eet and numb	oer)		4b. City,	Town, or	Location	of Death			4c. County	of Deeth		
			211 Milldale	Lane					isbu					Wicon	mico		
	Funeral		5. Social Security Number	6. Sex	7 4 25(2) F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Yea	ar)	9. Birth	olece (State o.	r Foreign
	Director		220-01-8918		/ 2 <b>X</b> -1	85	Yrs.					April 2	5, 1	919	Mary	land	
	pur * _		Usual Residence of Decedent  10a. State 10b. County	,		10c. Cit	y, Town or Lo	ocation								I0d. Inside Cit	ty Limits
	Aaryl Feho	ō	M33 1775			Co.1	i abuser									1 🗌 Yes	2 No
	28a-	ect	Maryland Wicol	ii1CO		Sai	isbury	10f. Zic	Code		-		10a. (	Citizen of V	What Cou	ntry?	
	with or	ᅙ							21804	1				USA		•	
	ns 23	Funeral Director	211 Milldale L		. Was Deced	ent Ever in U	.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	ecity Yes or N	lo-	14. Rac		can Indian,	
10	r Itan	F	1 ☐ Never Married 2 ☐ Ma	ried	Armed Ford 1 ☐ Yes 2 If Yes, Give			If Yes, spe	cify Cuba	in, Mexicar	n, Puerto	Rican, etc.)		Blac	k, White,	etc.	
ဗ္ဗ	urs a		3 Widowed 4 □ Divorce	b	If Yes, Give Year or Dat	es:		1 🗌 Yes	2X No	Specify:				Specify	′: W	hite	
21215-0036	72 hours after death with the Maryland Instural', or Itams 23e or 28s-f ehow dical Examinar must be notified at	Completed by	15. Decede (Specify only highe				16a. Dece	dent's Usu	al Occupa	ation during mos	t of work	na	16b.	Kind of Bu	ısiness/In	dustry	
21	e. Mag	npie	Elementary/Secondary (0-12)	31 g/a00 C	College (1-4	for 5+)	life.	DO NOT u	se retired	()	0 100	···9	E	lectr	ic		
7	e filed within al Hyglene. I other then " vent, the Me	ပ္ပ	12		2		Secr	etary					Po	ower (	Compa	any	
Maryland	d oth	Be	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	(First, Middl	e, Maid	len Sumam			
yla	should be ind Mental marked o	ို	Elijah C.		Care	У					ther			F.		Suther]	Land
ar	and and is my		19a. Informant's Name/Relation									I Route Num					201
	1 and 2 Health		Patricia S. Wi	.lgus	(da	ughter				and 'I			-				301
Ore	of H H ite		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Rer	noval from St	ate Sp	Place of Dispo cemetery, creating ringhi	sition (Nai Patory or c	me or other plac MOLV	(9)		ate	20c.	Location -	City or To	own, State	
Ē	Pages ment of ant: If it		4 ☐Donation 5 ☐ Other (	Specify)			rdens			P	-	17, 200	-				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Mudical Examinatorial Examinatorial Promitted at once.		21. Signature of Funeral Service	Ligensee	0	Nr. a	2:	Name ar	nd Addres Way	Funer	al H	ome Pr	ofe	ssion	al As	ssociat	cion
ш_	g ∪ ∺ a g		MAHO	Usu	14/	4560		501 S	now	Hill	Road	, Sali	sbu	ry, M	aryla	and 2.	1804
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, 0	certificate be executed nding physician and use as the burial-transit	Ex	resulting in death) Last	ı	Due to (o	r as a conseq	uence of):										
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9 x	death certifica attending pt d for use as tf	Me	IF FEMALE:	230	If yes outco	ome of pregna	ancy										
Вох	death c	ian	23b. Was decedent pregnant in the past 12 months?	250	1 Live bin	th 2 ☐ Feta	l death 3	☐Ectopic p☐Other (sg						23d. Dat Mor	e of deliven		/ear
o.	0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unknov		JOHIN 31	_ 0.1101 (3)	Journey								
مٔ	res that the disigned by the label detached		Part II. Other significant condit	ions contr	ibuting to dea	th but not res	ulting in the u	inderlying o	cause give	en in Part I		23e. Did	tobacc	o use contr	nbute to ti	ne cause of de	eath?
sp	requires been sign	d by										1 🗆	Yes	2 <b>Y</b> No	3 🗆 Prob	abiy 4 ∐U	Inknown
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B	i <b>cian</b> : Th certificate rector, pag	o C	25. Was case referred to medic	21						00 Di	-4 D4	1 Yes		No 1	Yes	2LJ No	
₹		o Be	examiner?  1 Tes 2 No		spital:	patient 2	ER/Outpatie	nt 3□ D0	Oth	0.00		Check on		s []O+b-	(C)		
o		-	27. Mapner of Death		28a. Date of	Injury	28b. Time o		28c. Injun Worl	4 🗆 140		me 5 Res 28d. Describe				y)	
on	ding h. h. After funer	tior	t <b>v</b> Natural 5 ☐ Pend	ng igation	(Month	, Day Year)	Injury	М		k? Yes 2□	No						
S	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	_		of Injury - At h		reet, factor	y, office			28f. Location	(Street	and Numbe	er or Rura	I Route Numb	ber,
Division	after after Dire	ertification;	4 Homicide			g, etc. (Special						City or To	own, Sta	ate)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	dical C	(Check only 2 Medica	ng Physic I Examine	r: On the bas	est of my kno	owledge, deat ation and/or in	h occurred ivestigation	at the tin	ne, date an pinion, dea	nd place,	and due to the	e cause	(s) and ma and place, a	nner as s	tated. the cause(s)	)
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Q			30. Name and address of person						24.a.		_4 4 -	102 0-	7	h	M	ر جمادی	21004
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		1 - For State Registrar	State of Maryland / I	Оера		lealth and M	Mental Hygi	•	20051
		Decedent's Name (First, Middle, Last)					2. Date of Death	l	3. Time of Death
Physicia /Medic Examin	al	James Earle Tea			4b. City, Town, or	Location of Death	August 1	Day Year 1 2004 4c. County of De	06:30 A ^M
Examin	CI	414 Perry Lynch R			Millin			Queen	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bii	rthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
Director		220-26-3820 Usual Residence of Decedent	^{1M 2□ F} 76	Yrs.	months Suyo	110010	March 4	, 1928 Ma	ryland
Now H		10a. State 10b. County	10c. City, Tow	m or Lo	cation	-			10d. Inside City Limits
6-1 st	ctor	MD Queen A	nne Milli	ngt	on				1 ☐ Yes 2 🛣 No
iges 1 and 2 should be lited within 72 hours after death with the Maryland it of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It is marked other then "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinar matter in all the matter at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
s 238	erai	414 Perry Lynch R	oad  12. Was Decedent Ever in U.S.	12.1	2165		anife Van an Na	USA 14. Race - Am	adopt Indian
them	Fun	11. Marital Status 1 ☐ Never Married 2√CXMarried	Armed Forces?  1 ☐ Yes 2 ☑ No	13.	f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, Wh	
FA I	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1□Yes 2√√ No	Specify:		Specify: W	hite
natur diced	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a completed)	(Give	ient's Usual Occup	during most of work	ring	6b. Kind of Busines	s/Industry
then then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired cian/busi	" iness own	or	Music	
Hygi Sther ant,	Φ	17. Father's Name (First, Middle, Last)		usı	Clair, bus		e (First, Middle, M		
fental fental rkad	To B	James Earle Teat	Sr.			Pauline	Ringgold	1	
and M		19a. Informant's Name/Relationship (Ty	pe, Print) 19b	. Mailir	g Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
ealth m 27 in		Nancy Carol Teat/						ton, MD 2	
rages I nent of H ant: If ital ary or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ P	emoval from State cemete	ry, crer	sition (Name of natory or other plac	·e)		Oc. Location - City of	r Town, State
rtmen rtant: njury		' 4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Euneral Service License			Cemetery  Name and Address		4/2004 (	Crumpton,	Maryland
permit. Pages I and 2 Department of Health at Important: If itam 27 is any injury or other treu		21. Signature of Earler at Service Licens	elkely )	Fe	ellows He	lfenbein	& Newnam	Funera1	Home, P.A.
		23a. Part1. Enter the discuse, or our pli shock, or heart failure. List only or	coron that caused the death. Do	not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	llington,	MD 21651 Approximate Interval Between
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Examiner	_	Sequentially list conditions,		10					
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ttendi or use	ian/I	23b. Was decedent pregnant in the past 12 months?	<ol> <li>If yes, outcome of pregnancy</li> <li>1 ☐ Live birth 2 ☐ Fetal death</li> </ol>		Ectopic pregnancy			23d. Date of de Month	elivery Day Year
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wrequies trai the beath centilizate been signed by the attending phys should be detached for use as the	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in	n the ui	ndarlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
I on the thospitel or Attending Prysician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death.  To tha Funarel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	ed b	CONDESTINE	•	-	ilin		1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
as ber 2 sho	piet	Mhuratan	O ANTHRUL	フ			24a. Was an autopsy	4b. Were a	autopsy findings available completion cause of
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er dez rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa	ırm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
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vithir To th comp	Me	286. Signature and title o certifier	100 n		29c. License	number	290	d. Date signed (Mor	th, Day, Year)
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		30. Name and address of person who co			$\sim$	0 01 1	١.		
Ct-	to	1ATRICIC J. Shoura 31. Date filed (Month, Day, Year)	Man HI) 13050	een	KD Biologic	) Cheste	ertaun h	10 2162	<u> </u>
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 0047AM **Physician** ,2004 Wilson nompson narles tugust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner River Hospital Center er town inester Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days 1 XM 2 ☐ F August 21, 218-48-5902 1947 Maryland 56 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County 28a-f ehow the Medical Exemines must be notified at 1 ☐ Yes 2X No Maryland Queen Anne Church Hill Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or 21623 USA 5312 Church Hill Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. ģ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumation. Realtor Real Estate 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Christine Starkey Samuel Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Vicky Lynn Higgs/daughter 5318 Church Hill Road, Church Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/19/2004 Church Hill, MD Church Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fellows Helfenbein & Newnam Funeral Home, P.A. Kuka 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21620 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 18050 resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Completed by Physician/Medical as the IF FEMALE USB 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months? Month Day detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 ( 2 12 No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PR/Outpatient Certification: To 3 DOA this 28c. Injury at Work? 27. Manne of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Injury Matural 5 Pending investigation after death.

I Director: Af in by the fur 1 Tes 2 No 2 Accident 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours aft ie Funeral Di letely filled in t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2 1) 3605 X who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person rean Ad CHEBENFE AUNDHON PATRICA C 32. Registr & Signature 31. Date filed (Month, Day, Year) State AUG 1 9 2004 > Registrar

DHMH 17 Rev 1/2001

THOMAS

OGDEN

JOSEPH

			For State Registrar	State of	Maryland			of Health a of Death		tal Hygien		and the last transfer
	Physici		1. Decedent's Name (First, Middle  John F. Taylor	•						Date of Death	Ay Year	3. Time of Death 9:47 a M
	/Medic Examir		4a. Facility Name (If not institution	, give street and numb	oer)			wn, or Location of	of Death	4	c. County of Death	
	Funeral		Holy Cross Hos  5. Social Security Number	6. Sex 7.	Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Y	r Sprin	24 Hrs. 8. [	Date of Birth Month, Day, Year	ontgomer	y place (State or Foreign intry)
ŀ	Director		229-32-3504 Usual Residence of Decedent	1 <del>M</del> 2 □ F	74	Yrs.	Months	ays Hours		rch 15,	1930 Vi	rginia
	aryland show	J.	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-f	Director	MD Monts  10e. Street and Number	omery	Si	lver S	pring 10f. Zip Co	de		10g. C	itizen of What Cou	
	23a o	al D	2004 Coleridge	Drive #201			20902			US	A	
ယ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ances.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Deced Armed Forcied 1 DYes 2 If Yes, Give	es?		f Yes, specify	t of Hispanic Ori Cuban, Mexican	n, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White	, etc.
Maryland 21215-0036	hours a tural', c	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es:		1 Yes 2 X	•		105	Specify: Bla	
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land	uld be f Aental H rked of tic eve	To Be	David Taylor						n Chri:		n Sumame)	
Mary	2 short and h		19a. Informant's Name/Relations								or Town, State, Zi	o Code)
re,	s 1 and f Health fem 27 other t		Etta Taylor/wif		20b. P!	Annual Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the	Stition (Name of matory or other	· Mattp	an, Ma		ocation - City or T	own, State
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Balt	permit. Depart Import any inj		21. Signature) of Funaral Service	Licensee	Sis						kins Fun gton, DC	eral Home 20011
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	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	C PANC		IS				-	
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.O. Box	at the death certifics by the attending phatached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Fetel nt at time of de	death 3	Ectopic pregr Other (specif				23d. Date of deliv Month	ery Day Year
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	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2X E	ER/Outpatien	t 3 DOA	0.1	of Death (Ch.		6 ∐Other (Specil	(v)
Division of	Attending Physician: r death. sctor: After this certific. by the funeral director,		27. Manner of Death  1 XNatural 5 Pendin 2 Accident investig	ation	Injury Day Year)	28b. Time of Injury		Injury at Work? 1  Yes 2  N	28d.	Describe how inju		
DIX	tal or Attenders after death al Director:	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place of	Injury - At hor , etc. (Specify)	me, farm, stre	eet, factory, of	fice		ocation (Street ar City or Town, State	nd Number or Rum e)	al Route Number,
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	To the within 2	Σ	29b. Signature and title of certifier		<u>u</u>	0	29c. Li	cense number			ite signed (Month,	
'	100		30. Name and address of value	Who completed cause	of death (Item	23a) (Type 1		8862		8	- 16 - 20	04
	UR (8)		Henry Chu, M.D	. 1500 For	est Gle	en Rd,		r Spring	g, Md.	20910		
•••	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 4 20		istrar's Signati		2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Robert E. Tripp 5:45 PM Aug. 17, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery National Lutheran Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28, 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 157M 2□ F 74 Wash., DC 578-36-8772 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiens, as a shirt if item 23a or 28a-f show ant. If item 27 is marked other than "natural", or litems 23a or 28a-f show ury or other traumatic event, it is Mardical Exam has must be notified at Rockville Md. Montgomery YOYes 2 □ No Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20850 USA 9701- Veirs Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status fy Yes 2 No If Yes, Give 52 - 53 Year or Dates 52 - 53 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S.Govt. Budget Analyst 5+ 18. Mother's Name (First, Middle, Maiden Sumame)
Helen L. Wilcox 17. Father's Name (First, Middle, Last) Be Henry Edward Tripp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213-Deer Lake La., Derwood, Md. 20855 19a Informant's Name/Relationship (Type, Print)
Mrs.Anna Poole-Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rockville, Md. Parklawn Mem.Park 8/21/2004 rtment rtent: I njury o 4 ☐ Donation 5 ☐ Other (Specify) permit. Departr Importa 21. Signature of Funeral Serv 22. Name and Address of Facility Hysong Co., Inc.
6510-16th St., NW, Wasl
sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Wash.,DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Dualo (of a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due-to-(or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit onsequence of) use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month fo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I the th 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part II. ģ Records. Non 1 | Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

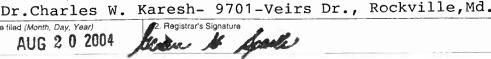
1 ☐ Yes 2 ☐ No page 2 s 1 ☐ Yes 2 1 No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to examiner? 26. Place of Death (Check only one) Be medical Other: 4 Thrising Home 5 Residence 6 Other (Specify, Hospital: ဥ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 EPVOutpatient 3 DOA this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Box 68760

31. Date filed (Month, Day, Year) AUG 2 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

18

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** George Severn Tyler, III 0205 18,2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours 69 Yrs. Director 219-30-3081 Baltimore, MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Christionsted, St. Croix North St. X Yes 2 □ No Director 10f. Zip Code 00820 10e. Street and Number 10g, Citizen of What Country? 5 U.S. Virgin Islands Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give² Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or White 1 ☐ Yes X☐ No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I and 2 should be filed within a fealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Self employed Developer/ 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Steadman Be George Severn Tyler, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 North St. Christionsted, St. Croix, VI.00820 Cynthia Patterson Tyler f Health item 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Hamportent: If ite any njury or of once. Capitol Crematory 8-18-2004 Dover, De. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) R. Carroll Hurley Funeral Home, P.C. 21. Signature of Funeral Service Licensee P.O. Box 518, St. Michaels, MD. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Days disease or condition resulting in death) /Medical End Stage Liver Disease
e to (or as a consequence of):

End Stage Liver Disease
e to (or as a consequence of):

Circles of the Liver Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 - Other (specify) P.O. 1 9 Unknown 9 Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diseose Renal 1 Yes 2 No 3 Probably 4 Unknown Completed Gastoentestre 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 20 No 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certified 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damian Sooklal 607 Dutchmans Lane, Easton, Md. 21601 31. Date filed (Month, Day, Year) AUG 20 2004 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Maryland	-	rtment of F				0	
			Registrar  1. Decedent's Name (First, Middle, Last,			inouto or	- Cairi	2. Date of De	Rag. N6)	<del>J () 4</del>	3. Time of Death
	Physici	an	1.	/				Month	Day	Year	M M
	/Medic Examin		4a. Facility Name (If not institution, give		<u> </u>	4b. City, Town, o		eath J		Dunty of Death	3.33 /3
			University of Mary	lard Medical Cc.	ter		nore				
	Funeral Director		5. Social Security Number 6. Sec. 10	7. Age (In yrs. last	t birthday) Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bin (Month, Da Aug. 2	y, Year)	9. Birthp Cour Virg	
	D.		Usual Residence of Decedent								
	show		10a. State 10b. County	10c. City, T	own or Loc	cation				1	0d. Inside City Limits
	8a-f	ç	Maryland Prince G	eorges Bow	vie						1 X Yes 2 □ No
	or 2	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citize	n of What Cour	ntry?
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8	tura stura	ed	15. Decedent's Edu	cation 1	l6a. Deced	ent's Usual Occup	ation		16b. Kind	of Business/In	dustrv
21215-0036	n n	Completed	(Specify only highest grad	e completed)	(Give I	kind of work done OO NOT use retired	during most of	working			,
212	t within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Presi	dent/Own	er		Cons	structio	on Company
Þ	a filed Il Hygik other vent, I	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,			Zan Ovinp Garaj
Maryland	2 should be filed w and Mental Hygie Is marked other traumatic event, II.	ToB	Robert	Husban				n Katheri			
Mai	12 sh h and 7 is n iraun		19a. Informant's Name/Relationship (T) Frank Wilusz/ Husb					r Aural Aoute Numbe ne, Bowie,	•		
ď	1 and 2 Health tem 27 l		20a. Method of Disposition		200	sition (Name of	Ing Lai	Date Downe		tion - City or To	
3altimore,	ages or o		1   Burial 2 □ Cremation 3 □ F	lemoval from State	etery, crem	atory or other plac	'				
謹	it. Partmer		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Lights</li> </ul>	Ced		.11 Cemet				and, Ma	
Ba	permit. Pages 'Department of h Important: If ite any injury or of		21. Signature of Fulleral Service Littles					Robert E. Road, Bowi			
			23a. Part1. Enter the disease, or compl	ications that caused the death.						ryrand	20715 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	1		g, 00011 00 00.	and of roop natory an			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Intra Abdon	, ^6	Sepsi	>				
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		ē	Sequentially list conditions,	Due to (or as a consequen	oce offi	r. 2 014	0	136636			
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9	ntifica ng ph		IE EENALE.						-		
Вох	leath certifica attending ph for use as th	an/h	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy			230	d. Date of delive	
.O. E	ne dea the at hed fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown		Other (specify)				Month	Day Year
Δ.	that the de ed by the detached		Part II. Other significant conditions co	ntributing to death but not resulting	na in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to th	ne cause of death?
rds,	sign d be	ed by						101	-		
of Vital Record	aw requ s been 2 shoult	Completed						24a. Was		24b. Were auto	psy findings available
Ä	The tay ate has page 2	E O					-	— autop perfo 1 ☐ Yes	rmed?	death?	npletion of cause of
ital		0	25. Was case referred to medical				26. Place of	Death (Check only o		1 103	20110
>	y S	To B	examiner?	lospital: 1∰Inpatient 2□ER	/Outpatient	3□ DOA Oth	er: 4 🗆 Nursin	ng Home 5 Resid	dence 6	Other (Specify	<i>(</i> )
0	ng Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injur	/ at	28d. Describe i			
io	ath. r: Af	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 22,	,,		Yes 2 □ No				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tov		lumber or Rura	l Route Number,
	ospita hours ineral y filled	alC	29a. Certifier 1X Certifying Phy	sician: To the best of my knowle	edge, death	occurred at the tin	ne, date and p	lace, and due to the	cause(s) an	d manner as st	ated.
	n 24 he Fu	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death o	occurred at the time,	date and pla	ace, and due to	the cause(s)
	To the comp	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
			1):-1	W FM.D		D 1.	5810		8/1	18/04	
			30. Name and address of person who co	empleted cause of death (Item 23	Ba) (Type, F						
			David Dexter	30 E. OSH	end	31	Sultimo.	re MD	212	30	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 0	32. Registrar's Signature	#	book				/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 8-20-04 Registrar Amend # 7.Per FH PGCcr 28261 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 350 PM Bortha Wiley August 16, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Randalls town Baltimore Northwest Hospital CEVITEV If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 58 1 □ M 2 X F 183-36-927 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 Is marked othar than "natural", or Items 23a or 28a-1 show traumatic evant, It a Madical Exporter must be notified at 1 XYes 2 ☐ No Be Completed by Funeral Director Va dwar ville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 201 23901 haure 39 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 5 3 ☑ Widowed 4 ☐ Divorced lack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hair auti 1 ( CIan 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked any injury or other traumatic events. 1800 Ohnson 85613 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Houchuca SON rcle Nelre 103A Henry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State • 4 □ Donation 5 □ Other (Specify) ellous 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E99 165 tow UH. 91450. MAIN 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CIWNOSIS /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last choiangitis Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown rtal hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Cronn's disease autopsy performed certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident I Diractor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To tha Funaral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - ,MD 00060567 August 16 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maying Nejia, MD

State

State State 31. Date filed (Month, Day, Year)

Registrar

AUG 2 0 2004

Old Walve Road Randallstown

oth, Day, Year)

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See St. Signature

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Maylana

			For State Registrar	State of N	Marylan		artmen rtificate				ental Hy	gien Reg. N	MAGI	28261
	Physici	an	Decedent's Name (First, Middle,		-						2. Date of D Month	eath D	ay Year	8.4
	/Medio Examir		Carol J. Watfo		er)		4b. City,	Town, or	Location of	of Death	August		1 2004 c. County of Dea	
	Lķaiiii	ıçı	7122 Marbury Cou	rt			Dis	tric	t He	ights			Prince (	George
	Funeral		5. Social Security Number 6		Age (In yrs. I		If Under Months		If Under		8. Date of Bi	rth av. Yea	9. Bi	rthplace (State or Foreign
	Director		243-92-1950 Usual Residence of Decedent	1 W 2 E31	54	Yrs.					July 2	27,	1950 Ah	oskie, N.C.
	ow or		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Man Man	tor	Maryland Prince	George	Dist	rict l	Heigh	ts						1 ☐ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of What C	ountry?
	ath w		7122 Marbury C					747					ed Stat	
	items items	Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2	s?	S. 13. \	Was Deced If Yes, spec	lent of Hi rify Cuba	spanic Ori n, Mexican	gin? (Spe n, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	Z€ No	Specify:				Specify:	Black
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2	within lene. than	mpie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	DO NOT us	e retired,	)		<i>'</i> 9			
2	be filed within 7: nal Hygiene. od other than "n event, the Madi		1 Z 17. Father's Name (First, Middle, La	ist)		Compu	ter I	echn			(First, Middle			vernment
au	d be ental ked o	To Be	James Watfor							ie Wa		, maide	in ourname,	
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic eve	-	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	Route Numb	er, City	or Town, State,	Zip Code)
	2 = 2 T		Alice Watford/Si	ster				_	ourt,	Dis	trict	Heig	ghts, MD	20747
o e	<b>Φ</b> Ω − ►		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from Sta	te Fig	lace of Dispo emetery cren St Bap	sition (Nan	ne of ther place	ch =		ate		Location - City or	
Baltimore,	t. Pag rtment rtent: njury		`4 □Donation 5 □ Other (Spe	cify)	Cem	etery				8/28			erain, N	1.C.
Bal	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Li	V. Me	ll	55	38 Ma	rlbc	ro P	ike,		vil	es 1e, MD	20747
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	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>CO</u> (	02		-A	2	CE	R				
	Examiner			Due to (or	as a cons <del>e</del> qu	ience of):								
þ.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a cons <del>e</del> qu	ience of):								
	ocuted nd transil	Examine	Cause (Disease or injury that initiated events	c										
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or a	as a consequ	ience of):								
387	certificate be executed ading physician and use as the burial-transit	edicai	N	d			·							
Вох 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date of de	livery
	death e atten	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth	at time of de		]Ectopic pre ] Other (spe						Month	Day Year
P.0	at the by th tache	Phys	9 🗆 Unknown	9□ Unknown										
Ś	se und	by	Part II. Other significant condition	s contributing to death	n but not resu	ilting in the ur	nderlying ca	luse give	n in Part I.		_		_	o the cause of death?
Record	≥ Ω σ	ompieted									24a. Was	an	24h Were a	utopsy findings available
Re	e T 6	ошо									auto perfe	ormed?	prior to death?	completion of cause of
Vital	icien: Th certificate ector, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only		0 1 108	2 2 140
<b>o</b>	ys Sis	To	examiner? 1 ☐ Yes 2 <del>☐ No</del>		atient 2 🗆 E	ER/Outpatien	t 3 🗆 DO.	A Othe	r: 4□ Nui	rsing Hom	ne 5 esi	dence	6 □Other (Spe	ocify)
		ion:	27. Manner of Death  1 Natural 5 Pending		njury Day Year)	28b. Time of Injury		Bc. Injury Work	?		8d. Describe	how inju	ury occurred	
Division	or Attending after death. Director: After in by the fune	ertification;	2 Accident investigat 3 Suicide 6 Could no	t be 200 Place of	Injury - At ho	me farm str	M factory		′es 2□N		8f Location (	Stroot a	and Number or Pi	ural Route Number,
Σ	or Dir	ertii	4 Homicide determine	building,	etc. (Specify	)	oot, tablory	, 011100			City or To	wn, Stai	te)	arai riodio rumbor,
	Hos Pur 4 ely	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			_	1	License				29d. Da	ate signed (Mont	h, Day, Year)
•						MI	DI	5	81	82		Mu	gust 2	3,04
(	K (6)		30. Name and address of person who Donald C. George				Print)				eenha1	t 1	MD	,
	Sta	te	31. Date filed (Month, Day, Year)	2. Regi	strar's Signat	ure		~y,	Jee I	GL	CCHDET		ш	
	Registr	aŕ	AUG 2 4 20	U4 Media	U SK	1000	W							

			1 - For State Registrar	State of Maryland		artment of <i>tificate of</i>				ene g. No,?	nnu	28252
	Dhusisi		1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
-	Physici /Media		Robert Bruce Wes	st				Αι	igust	18,	2004	1:00 P M
	Examir	er	4e. Fecility Name (If not institution, give st	treet and number)	ĺ	4b. City, Town,		of Death		4c. Co	unty of Death	
			9704 Beaver Dam Ro 5. Social Security Number 6. Sex		at histogram	Timon If Under 1 Year		24 Hrs o	Date of Birth	Ва		County
н	Funeral Director			M 2□F 7. Age (117 yrs. 1a	.,	Months Days		Min.	(Month, Day, 1	Year) 1961	9. Binni	plece (State or Foreign htry)
			Usual Residence of Decedent	43				J	111. 4,	1901	16	xas
	ylanc		10a, State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	a-fe	ctor	Maryland St. Mar	y's Le	xingto	on Park						1 ☐ Yes 2X No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10	g. Citizen	of What Cour	ntry?
	23a		19721 Teddy Road			20653				U.S.		
	ar de	Funeral		<ol> <li>Was Decedent Ever in U.S Amed Forces?</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>	i. 13. V	Was Decedent of f Yes, specify Cul	Hispanic Orig ban, Mexican	gin? (Specify i, Puerto Rica	Yes or No- an, etc.)		Race - Americ Black, White,	
36	rs aff	by F	1 ☐ Never Mamed 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 24≜14No If Yes, Give Year or Dates:	1	I□Yes XXN	Specify:			Spi	ec <i>ify:</i> Whi	to
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7	d with	E O	12th Grade	5511age (1-451 54)	Ma	intenanc	e			Но	using	
덛	al Hy l othe	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (Fi	irst, Middle, Ma	aiden Sur	mame)	
Maryland	Ment Ment arkec	10	Donald Lee West, S	Sr.			Me1	vina J	Jane Ra	wlin,	gs	
an	2 sho and is my		19a. Informant's Name/Relationship (Typ	oe, Print)		ig Address (Stree				,		Code)
٥, ک	and lealth m 27 her tr		Kimberly A. West			l Teddy	Rd. Le	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon				
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Baltimore,	tmen tant:		'4 □Donation 5 □ Othern(Specify)			em. Gard		8-21-		Leon	ardtown	n, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f ehow amp injury or other fraumatic event, the Medical Examinational be notified at once.		21. Sign yuri o Funeral Service License	· Mou		Name and Addr 2955 Hol						ome, P.A.
	- *		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the death.							11, FHD 2	Approximate
ì	Physician		Immediate Cause (Final	e cause on each line.	m	. #	•					Interval Between Onset and Death
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Light	- X - X	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (b) s a conseque	ence of):							-
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ő,	e exe	Ě	resulting in death) Last	Due to (gras a conseque	ence of):							10tys
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SD	uires r sign	d by							1 Yes	2 🗆 N	o 3 🗆 Prob	abiy 4 □Unknown
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ta		a)	25. Was case referred to medical				26 Place		1 ☐ Yes 2 heck only one)	No	1 🗆 Yes	2 No
Division of Vital Records,	Physician: The ribis certificate hirral director, page	0 0	examiner? 1 ☐ Yes 2 No	ospitat: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA O			5 Residen		Other (Specifi	(Hotel
0	ding Phys h. Atter this funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			Describe how			HOCCE
Ö	Attending it death. actor; After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(, 2.2)	,,		Yes 2 1	No				
Σ	f or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f.	Location (Stre		umber or Rura	l Route Number,
	ital or irs afte ral Dir											<u> </u>
	Hosp 14 hou Fune Fune	edical	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examination	rledge, death on and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and th occurred a	due to the cau	se(s) and e and plac	l manner as st ce, and due to	ated. the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; Atter completely filled in by the funer	Med	29b. Signature and title of certifie	and manner stated	~		se number				gned (Month,	
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h	N		30. Name and address of persoa who co	Toleted Alf death (Item)	UICL	- 2257	6 MacA	rthur	Blvd.	Cali	fornia	MD 20619
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire /		2 114011			JULL	LULINIA	۷۵۰۱۶ سد
	Regist		AUG 2 n 2004	13 mar a las	1	129						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Henry Lee Willis 2004 August 16 19:02 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Month, Day, Year) Oct. 17, 1921 Prince George's 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 <del>∏</del> M 2 □ F 224-24-5643 Director Virginia Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location iral', or itams 23a or 28e-f show Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6701 Danford Drive 20735 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e any injury or other traumatic event, the Medical Exactiner Install 20nce. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Hes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2万 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mover Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Sally Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Foster - Daughter 6701 Danford Dr., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cem. 8/23/2004 Triangle, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART /Medical Due to (or as a consequence of): Examiner JERIKL OCCLUSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attanding Phyaician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CELEBROVASCULAR ACCIDENT Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANZMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 2 Accident 5 Pending nours after death.
naral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48158 chosing same AUG 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISON CSIA 6192 OXON HILL ILOAD # SOO CXON HILL MD 2076 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 2 4 2004

110.7			1 - For State Registrar	State of Mary		artment of H			giene leg. No.2	004	28264
CAL	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media			. Williams				August	15	2004	10:10 A M
	Examir	ner	4a. Facility Name (If not institution, give s	· ·	C tr	4b. City, Town, or			4c. Coun	ity of Death	
			Forest Glen Nursi  5. Social Security Number 6. Sex		yrs. last birthday)		Lver Spr			Montg	
	Funeral Director		578-14-0463	M 2DE	34 Yrs.	Months Days	Hours Min.		Year)		lace (State or Foreign stry)
	ס		Usual Residence of Decedent					TED. 2	1720	was	h., DC
	anylar show	_	10a. State 10b. County	100	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	8e-f	Director	DC				shingto				1X Yes 2 No
	with t		10e. Street and Number	mda Arra D	7 17	10f. Zip Code	20000	1	0g. Citizen of		
	eath	eral	1513 W. Virgi	12. Was Decedent Ever		Was Decedent of Hi	20002	Specify Ves or No.		Jnited	States
(0	r Iten	Funeral	1 Never Married 2 Married	Armed Forces? 1XTYes 2 ☐ No		Was Decedent of Hi If Yes, specify Cuba		to Rican, etc.)		ack, Whate	
ဗ္ဗ	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2X No	Specify:		Spec	ity: Am	erican
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usuai Occupa kind of work done o	lurina most of wo	rking	16b. Kind of	Business/Inc	lustry
121	Mithin ne. han	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)				
5	Hygie Hygie Ither t		9th 17. Father's Name (First, Middle, Last)			Eng	ineer	me (First, Middle, I		vernm	ent
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3	shoul nd Ma marl	-	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street a	and Number or Ri			n, State, Zip	Code)
ž	nd 2 alth a 27 is		Claire B. Willia	ms - Wife		3 W. Virg					20002
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, Ita Medical Examinat must be notified at ance.		20a. Method of Disposition	1	Ob. Place of Dispo	osition (Name of matory or other place	9)	Date	20c. Location	- City or To	wn, State
<u>Ĕ</u>	Page ment ant: If ury or		1 ∑Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State	-	lemorial C	-	1/2004	Suit	land,	MD
alt	permit. Departi Import. any inj any inj		21. Signalure of Juneral Service License	90	_ 22	2. Name and Addres		Stewart F			
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock or heart failure. List only on immediate Qause (Final disease or midition resulting in death)  Sequentially list conditions	Due to (or as a con	of free	er the mode of dying	g, such as cardiad	c or respiratory arre	əst,		Approximate Interval Between Oriset and Death
	icate be executed physician and s the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con							
P.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver onth i	y Day Year
rds, ⊦	The law requires that the tte has been signed by th page 2 should be detache		Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	a./		e cause of death?
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Vital	cien: ertific ector,	Be	25. Was case referred to medical examiner?					th (Check only one	9)		
ō	Phys this al dir	٠ <u>۲</u>	1 Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 U Norsing H	ome 5 Reside			
O	ding h. After funer	tion	1 Natural 5 Pending	(Month, Day Yea	ar) 28b. Time of Injury	Work	at ? ′es 2 ⊡No	28d. Describe ho	w injury occui	rrea	
Division of	Attending Physicien: r death. ector: After this certifics by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, str		7	28f. Location (Str	eet and Numi	ber or Rural	Route Number,
á	al or A s after al Dire	Serti	4  Homicide determined	building, etc. (S)	pecify)			City or Town			
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death mination and/or inv	n occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and m ite and place,	anner as sta and due to t	ted. the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	04		29c. License	number	29	d. Date signe	ed (Month, D	ay, Year)
,			· Whyon d.	Kukno	MD	1000	614	- 1	1 [9]	200	4
C	R (2)		30. Name and ad ress of person who con	m ted cause of death	(Item 23a) (Type,	Print) 2365	SHER	EFICA	DR	0	
	Sta	te	31. Date filed (Month, Day, Year)	A. Registrar's S	ignature _	WITE	MO	1 TOPE	1	2707	
	Registr	- 1	AUG 2 4 2004	Blow.	K Apo	le					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 7:00 P M August 17, 2004 C. Walker Myrtle /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Upper Marlboro 13500 Messenger Place Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 200 F 84 Yrs. Aug. 31,1919 Director Canada 093-22-2257 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or iteme 23a or 13500 Messenger Place 20774 Canada death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: Black þ 3€ Widowed 4 Divorced "neturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other It any injury or other traumatic event, IIIs 2002. Private Executive Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Theopolus Codrington Lillian McBeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Walker, III - Son 648 Fairview Ave., Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Xurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Sept. 3, 2004 Brentwood, MD 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee Ca Mondgoner taverne 3831 Georgia Avenue, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Carcinoma of Pancreas 15 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Enter Under ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 2No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide Fo the Hospitel X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medic≰I Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the P 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature as 0 D-17605 August 19,2004 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 7525 Greenway Center Dr., #215, Greenbelt, MD 20770 David Haidak, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 2 3 2004 Registrar

			1 - State Registrar	State of M	laryland / De <i>C</i>		Health and N		_	4 28266
ı	Physic	ian	Decedent's Name (First, Midd	le, Last)				2. Date of Death Month	Day Y	3. Time of Death
	/Medi			Francis	Werner			August	19, 2	004 9:00 PM
4	Exami	ner	4a. Facility Name (If not institutio		•	4b. City, Town, Croft	or Location of Death		4c. County of	
			Crofton Con							Arundel
	Funeral Director		5. Social Security Number 579-14-2817  Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. last birthda 82 Yrs.	Months Days		8. Date of Birth (Month, Day, ) Jun. 15	,1922	Wash. DC
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar Mar	to	Md. Anne	Arundel	Chi	ırchton				1 □ Yes 2 □ No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wh	at Country?
	1h wii	a	P.O. Box 86			2	0733		USA	
	ams er m	Iner	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S. 1:	3. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian, White, etc.
36	or It	Y.F.	1 Never Married 2 Mar	If Yes, Give A	No	1 ☐ Yes 2 ☐ No				
Ö	hour:	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:						White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itams 23a or 28a-1 show int, the Medical Evantine trust be recitied at	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire	during most of work	ing 16	b. Kind of Busin	ness/Industry
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p	be filed withintal Hygiene. Id other than	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, Ma		L 8
lan	ರ್ಷ ಕ್ಷಾಹ್ಮ	To B	Н	arry Whibl	e v		Fr	ancis I	. IInde	rwood
Maryland	2 should and Men is marke aumatic	-	19a. Informant's Name/Relations	ship (Type, Print) days	htor 19b. Ma	iling Address (Street				
Σ	r 2 mg		Veronica A.	Lefebvre-	571	4 N. Sho				
ore	iges 1 and of Heal		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla		Date 20		ty or Town, State
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Baltimore,	permit. Pag Department Important: I any injury c	4	21. Signature of Funeral Servi	icens 17	> 1/	22. Name and Addre	ess of Facility B	eall Fur Hwy., E	eral H Bowie,	Home Md. 20715
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Pneum	ine.	inter the mode of dyir	ng, such as cardiac (	or respiratory arrest		Approximate Interval Between Onset and Death 3 days
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Lating (1850 of 1947) that initiated events resulting in death) Last	С	a consequence of):					
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	w requires that the been signed by th should be detache	by	Part II. Other significant condition  Deme		out not resulting in the	underlying cause giv	ren in Part I.	23e. Did tobac	_	te to the cause of death?  Probably 4 Unknown
Vital Records,	The law ate has b page 2 si	Completed						24a. Was an autopsy performed	i? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
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of	Physic this c	6	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		ent 3 DOA Oth	er: 4 Wursing Ho	me 5 Residenc	e 6 □Other (	Specify)
	ding P th. After t	on:	27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	of 28c. Injur Wor	y at k?	28d. Describe how		
Sio	Attanding Physician: r death. ector: After this certific by the funeral director.	cat	2 Accident investig	not bo			Yes 2 □ No			
Division	or Al	Certification:	4 ☐ Homicide determ	ined 288. Place of In	ury - At home, farm, s c. (Specify)	street, factory, office	T	28f. Location (Stree City or Town, S	t and Number o itate)	r Rural Route Number,
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	To tha Hospital or Attant within 24 hours after death To tha Funaral Director: completely filled in by the	edical	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner st	it examination and/or	nvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
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			Ihrs	h	M)	D35	848	Au	gust 2	0, 2004
_(	R(4)	i	30. Name and address of person Howard Schu				, Gambri	11s, Md	. 2105	4
	Sta Registr	125	31. Date filed (Month, Day, Year)  AUG 2 3 2	2. Registr	ar's Signature					

		1 - For State Registrar		State of	Maryland	-	artment rtificate			ind M		-	0001	53 C
		Registrar  1. Decedent's Name	/First Middle 1	net)		Cei	uncate	OT L	Jeath		2. Date of De	Reg. No.	<u> </u>	28267
Physic	an	JEAN	HEULIN		GHT						A LOLLS	Day	Yeer	3. Time of Death
/Medi Examir		4a. Facility Name (If					4b. City, To	own, or l	Location of	f Death	nugu	40.	County of De	ath
Exami	iei	Memori	-	spital a	_	ton	Eas						2160	
Funeral		5. Social Security No	umber 6. 5	Sex 7	. Age (In yrs. las		If Under 1	Year	If Under 2		8. Date of Bir (Month, Da	th	9. Bi	rtholace (State or Foreign
Director		151-14-92	.79	1□M 2 <b>X</b> F	83	Yrs.	Mortus	Days	Hours	Min.	JULY 9	,1921	L IN	EW JERSEY
ene. than "natural", or items 23a or 28a-f show na Madical Examinar must be notified at		Usual Residence of 10a. State	Decedent 10b, County		10c. City,	Town or Lo	cation							10d. Inside City Limits
Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or flems 23a or 28a-f show any njury or other traumatic avant, the Medical Examinat must be notified at once.	ō			· · · ·										Yes 2 No
28a-	by Funeral Director	MD 10e. Street and Nun	TALI	3OT		EASTO	N 10f. Zip C	ode				10g Citiz	en of What C	
3a or	ā			Æ., ROOM	105			216	01			-	J <b>SA</b>	outry:
ms v	nera	11. Marital Status		12. Was Deced	ent Ever in U.S.	13. \				in? (Spe	ecify Yes or No Rican, etc.)			erican Indian,
e de	Ē	1 Never Marrie	ed 2 Married	Armed Force	No No					Puerto	Rican, etc.)		Black, Wh	
E		3 Widowed	4 Divorced	If Yes, Give Year or Dat			1 □ Yes 2 <b>X</b>	U No	Specify:				Specify:	WHITE
dien.	etec	(Speci	15. Decedent's E	ducation ade completed)		(Give	tent's Usual (	done du	uring most	of worki	ina	16b. Kin	d of Busines	s/Industry
9 Mg	Completed	Elementary/Secon	· · · · ·	College (1-4	tor 5+)	life. L	DO NOT use	retired)	J		•	OT	N HOM	<b>.</b>
, i		12 17. Father's Name (	First Middle / se			HUM	EMAKER	_	40. 14-4-	4- 11-	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			<u>.                                    </u>
avar	Be	LLOYD	HEULING						18. Mother		(First, Middle,		Sumame)	
nark	은	19a. Informant's Na			-	105 Maille	- A - I						-	
traur				_		_					N Route Numbe			
ther		GEOFF WRI		<u> </u>			sition (Name		POTET		oate			r Town, State
0 10 /		1 X Burial 2	Cremation 3	Removal from St	ate cem	etery, cren	natory or other	er place,			2004			RYLAND
njur)	19	* 4 □ Donation 21. Signature of Fur	5 Other (Speci		OAFC									
any r		DM. E	1000	0400 111	CFSF									HOME, P.A.
-		23a. Part1. Enter th	e disease, or con	nolications that cau	used the death.						EASTO		2160.	Approximate
		shock, or hear Immediate Cause (I	t failure. List only	one cause on ead	ch line.		- 1				. roophatory ar	1651,		Interval Between Onset and Death
ician dical		disease or condition resulting in death)		a	spiratu		rail	u +	e von					Days
niner			1	A	r as a consequer	. ~~~	Pno		wen i					Do-C
	er	Sequentially list con	ditions,	b. — Due to (or	as a consequer	nce of it:								
transit	aminer	Cause (Disease or i	lying	CA	mic	Post	met	nè	Pul	mor	my &	rsea	10	Years
ai-tra	Exa	that initiated events resulting in death) L	ast		as a consequer		7000,0							1 - 4 3
s the burial-t	call			d										
as th	Physician/Medical													
for use as t	M/u	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco			le					23	3d. Date of de	livery
od for	icia	in the past 12 t	months?	4☐ Pregnar	h 2 ∏Fetal de nt at time of deat		Ectopic pregi Other (speci						Month	Day Year
should be detached	hys	9 🗌 Unknown		9□ Unknow	m 									
өр өс	ру Р	Part II. Other signifi	cant conditions	contributing to dea	th but not resultin	ng in the un	derlying caus	se given	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause of death?
pind	edl	Adri	7 76	rillation	~						1 🗆 Y	'es 2 🗆	No 3□P	robably 4 DUnknown
2 sho	Completed	Hyp	ertens	con							24a. Was		24b. Were a	utopsy findings available
age	mo										autop	med?	prior to death? 1 □ Yes	completion of cause of
tor.	0	25. Was case referr	ed to medical						26. Place o	of Death	1 ☐ Yes	25 No	1 🗀 7 08	2 <b>4</b> No
funeral director, page 2	To B	examiner? 1 □ Yes 2 🖎	No	Hospital: 1 Hop	patient 2 ER	/Outpatient	3 □ DOA	Other			ne 5 Resid		□Other (Sne	ecify)
neral		27. Manner of Death		28a. Date of (Month,		b. Time of		. Injury a Work?			8d. Describe h			
inj et	atic	1 Matural 2 ☐ Accident	5 Pending investigatio	n		,u.y	М		es 2□N	0				
in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of	f Injury - At home	, farm, stre	et, factory, o	ffice		2	8f. Location (S City or Tow	treet and	Number or R	ural Route Number,
ed in	Cer				, -, -, -, -, -, -, -, -, -, -, -, -, -						2.1y 31 10W	, 514(6)		
á≣	62	29a. Certifier (Check only	Certifying Pl	nysicien: To the be	est of my knowle	dge, death	occurred at t	the time	, date and	place, a	and due to the o	ause(s) a	nd manner as	s stated.
>	0													
npletely	Medical	0110)		and manne	r stated.	- array or irre				OCCUITE				
completely filled	Medic	29b. Signature and		and manne	r stated.		29c. L	icense r				29d. Date		h, Day, Year)

State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Usual Residence of Decedent  10a. State  10b. County  Maryland  So  10e. Street and Number  31029 Cooper  11. Marital Status  1 Never Married  1 Divorced  (Specify only highest  Elementary/Secondary (0-12)  n/a  17. Father's Name (First, Middle, L	Amerset  12. Was Decedent Every Amed Forces? 1	16a. Dec (Ginder)  19b. Ma  19b. Ma  20b. Place of Dis  Wicomi  Park	4b. City, Town, or Solution  4b. City, Town, or Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution  4c. Solution	1 17 (  853  Spanic Origin? (Specify, Mexican, Puerto Ric Specify:  ation furing most of working)  18. Mother's Name (F  Lauresa and Number or Rural R  Oper Lane Date 18 / 19 / ss of Facility Funeral Hill Rd.	y Yes or No- an, etc.)  First, Middle, M  Noute Number, Prince 2  / 2004  Home , Sali	4c. County of Deat  Year)  Year)  9. Bin  2004  Ma  Og. Citizen of What Co  USA  14. Race - Ame Black, Whit  Specify:  16b. Kind of Business  n/a  Maiden Sumame)  oten  City or Town, State,  cess Anne 20c. Location - City or  Salisbu  Professic  sbury, MD	hhlace (State or Foreign untry)  Tyland  10d. Inside City Limits  1 Yes 2 No  Pountry?  Prican Indian, e, etc.  Black  Industry  Zip Code) e, MD 21853  Town, State  LTY, MD  Donal Associated
Usual Residence of Decedent 10a. State 10b. County  Maryland 10c. Street and Number 31029 Cooper 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent (Specify only highest Elementary/Secondary (0-12) n/a 17. Father's Name (First, Middle, L Oliver P. Wig 19a. Informant's Name/Relationsh Oliver P. Wig 20a. Method of Disposition 1 Seurial 2 Cremation 1 Donation 5 Other (Sp 21. Signature of Funeral Service L shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Amerset  12. Was Decedent Every Amed Forces? 1	Prince  Prince  If a. Dec (Gr. life)  19b. Ma  Ather  20b. Place of Dis Wicomi Park  Park  Inches death. Do not e	In the state of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	It Under 24 Hrs. 8. Hours Min. 17 (  853 Spanic Origin? (Specify. 8. Aspectly: Ation fluring most of working  18. Mother's Name (F  Lauresa and Number or Rural R  Oper Lane (F) 18   8/19/ Ses of Facility Funeral Hill Rd  g, such as cardiac or re	y Yes or No- an, etc.)  Tirst, Middle, M.  Moloute Number, Prince 2  / 2004  Home , Sali	Vear)  Year)  Year)  Year)  9. Birl  2004  Ma  Og. Citizen of What Co  USA  14. Race - Ame Black, Whit  Specify:  16b. Kind of Business  n/a  Maiden Sumame)  oten  City or Town, State,  Cess Anne 20c. Location - City or  Salisbu  Professic  sbury, MD	hplace (State or Foreign untry)  Tyland  10d. Inside City Limits  1 Yes 2 No  Pountry?  Prican Indian, e, etc.  Black  Industry  Prican Indian, e, etc.  Black  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Indust
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Was Decedent Eve Armed Forces? 1   Yes 2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4	Prince  Prince  If a. Dec (Gr. life)  19b. Ma  Ather  20b. Place of Dis Wicomi Park  Park  Inches death. Do not e	Months Days  Location  Less Anne  10f. Zip Code  216  3. Was Decedent of Hilf Yes, specify Cuba  1 Yes 2 No  Recedent's Usual Occupive kind of work done of the Do NOT use retired on a line of the property of the place of the property of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of th	Hours Min. 1 17 (  353  Spanic Origin? 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Location - City or Salisbut Professic sbury, MD	Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Indust
Usual Residence of Decedent  10a. State  10b. County  Maryland  So  10e. Street and Number  31029 Cooper  11. Marital Status  1 Never Married  15. Decedent  (Specify only highest  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L  Oliver  19a. Informant's Name/Relationsh  Oliver  19a. Method of Disposition  1 Surial  2 Cremation  1 Surial  2 Cremation  21. Signature of Funeral Service L  23a. Part 1. Enter the disease, or a shock, or heart failure. List of large and the state of condition resulting in death)	I I M 2 S F  I M 2 S F  I Merset  12. Was Decedent Eve Armed Forces? 1   Yes 2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4 Yes   2   Xe   1/4	Prince  Prince  If a. Dec (Gr. life)  19b. Ma  Ather  20b. Place of Dis Wicomi Park  Park  Inches death. Do not e	Months Days  Location  Less Anne  10f. Zip Code  216  3. Was Decedent of Hilf Yes, specify Cuba  1 Yes 2 No  Recedent's Usual Occupive kind of work done of the Do NOT use retired on a line of the property of the place of the property of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of th	Hours Min. 1 17 (  353  Spanic Origin? 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Location - City or Salisbut Professic sbury, MD	Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Industry  Indust
Maryland Sono Street and Number 31029 Cooper 11. Marital Status 1 Never Married 2 Married 3 Middled 4 Divorced (Specify only highest Elementary/Secondary (0-12) n/a 17. Father's Name (First, Middle, LOliver 19a. Informant's Name/Relationsh Oliver 19a. Informant's Name/Relationsh Oliver 19a. Method of Disposition 1 Seurial 2 Cremation 1 Donation 5 Other (Specify only highest 19a. Informant's Name/Relationsh Oliver 19a. Signature of Funeral Service List of Service List of Immediate Cause (Final disease or condition resulting in death)	Lane  12. Was Decedent Eve Armed Forces? 1   Yes 2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   1   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes   2   200   2   Yes	Prince  or in U.S. 13  16a. 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disease or condition resulting in death)	b	onsequence of):	c dysp	IRSIA			BIRTH
Sequentially list conditions, if any, leading to immediate	b	consequence or).					
Sequentially list conditions, if any, leading to immediate cause. Fitter indexing.						- 1	
Cause (Disease or injury		consequence of):					
that initiated events	c						
resulting in death) Last		consequence of):					
	d						
							140
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 ☐Ectopic pregnancy	,		23d. Date of de	
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin		5 Other (specify)			Month	Day Year
9 🗆 Unknown							
Part II. Other significant condition	ens contributing to death but r	not resulting in the	e underlying cause giv	en in Part I.			
					1 ∐ Ye	es 2∐No 3∐Pi	obably 4 Unknown
						n 24b. Were at	utopsy findings available completion of cause of
					perform	ned? death?	
25. Was case referred to medical				26. Place of Death (C	Check only one	е)	
examiner? 1 Tes 2 No	Hospital: 1. Inpatient	2 ER/Outpat	atient 3 DOA Oth	er: 4□ Nursing Home	5 🗆 Reside	ence 6 Other (Spe	cify)
27. Manger of Death	28a. Date of Injury (Month, Day Y	Year) 28b. Time	e of 28c, Injur	y at 280 k?	d. Describe ho	ow injury occurred	
2 ☐ Accident investig	gation						
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	inna 200. Flace of Injury	y - At home, farm, (Specify)	, street, factory, office	28f			ural Route Number,
	1			1			
one)	and manner state	ed.					
	1		29c. Licens	e number	29	9a. Date signed (Mont	n, vay, Year)
MY JICHAC/J	(ne M)		D5	8578		Juguer 13,	2004
30. Name and address of person v	who completed cause of dea	ith (Item 23a) (Tyr	pe Print)			1	
/ /		00	11 -1	-11			
/ /	22. Registrar's	DE. CARK	will St. :	SAlisbun	y, Mo	2. 2180	/
	25. Was case referred to medical examiner?  1	25. Was case referred to medical examiner?  1	25. Was case referred to medical examiner?  1	25. Was case referred to medical examiner?  1	examiner?    Yes   2   No	24a. Was a autops perform 1 Yes 2  25. Was case referred to medical examiner? 1 Yes 2 No  26. Place of Death (Check only on examiner) 1 Inpatient 2 ER/Outpatient 3 DOA of their 4 Nursing Home 5 Reside 28d. Describe to 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury 4 Work? M 1 Yes 2 No  28d. Describe to 1 Yes 2 No  28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe to 28d. Describe t	24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1   Yes   2   No   3   Private   24a. Was an autopsy performed?  1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1312 Clinton 9 2004 Earl White August /Medical 4b. City, Town, or Location of Death Salisbury 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Keninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov. 17 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 F Director 213-14-6432 84 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Itam 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event. De Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Ouantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6148 Catchpenny Road 21856 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 11 Waterman None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph Augusta White Carrie Wigfall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Itam 27 Orsula White (Wife) 6148 Catchpenny Rd.Quantico, Md. 21856 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Ouantico 8-16-04 Quantico, Md. 21. Signature of Funeral Service Licensee Stewart Funeral Home  $\mathcal{B}$ : 821 West Rd.Salisbury, Md. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER MENTH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CONGEST, VE 1 Yes 2 No 3 Probably 4 Unknown HEART Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29168 I all

State Registrar

Box 68760.

P.O. |

Division of Vital

AUG 1 2 2004

31. Date filed (Month, Day, Year)

ALLEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

DIVISION ST. SALISBUAT MO

1346

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Physician 10:30A M 2004 Elizabeth Ellen Younker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 94 Director 219-36-2957 08/25/1909 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23e or 28e-1 ahow other traumetic event, the Medical Examinal must be multified at MD Hagerstown 1 XIYes 2 □ No Washington Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21740 106 B Bethel Street US Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 ☑ No Specify Specify 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If lien 27 is marked any injury or other 17. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lewis (unknown) Brumback Ellie (unknown) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 641 Pennsylvania Avenue, Hagerstown, MD 21740 Vernice R. Spruce / Daughter 20b. Place of Disposition (Name of Supreme Council Of House of Jacob Cem.

20c. Location - City or To Date Supreme Council Of the House of Jacob Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition candio vissale Physician 1 years resulting in death) /Medical Due to (or as a consequence of): **Examiner** enal 6 Month aune if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed aculi is then as the burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Completed by Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 III Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 2 □ No 3 ☐ Probably 🎉 🗇 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 2 certificate 1 Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending M 1 TYes 2 No investigation death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8.23-04, D28365 completed cause of leath (Item 23a) (Type, Print) Hagerstorm 19021790 Street SHUA 368 nuel 9AW2

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

32. Registrar's Signature

04-05682 Carl Ander RJD

Amend I tem I per me 6836 10 I tem I per me 6836 10 I tem I per me 6836 10 I tem I per me 6836 I tem I tem I per me 6836 I tem I tem I per me 6836 I tem I tem I per me 6836 I tem I tem I per me 6836 I tem I tem I per me 6836 I tem I tem I tem I per me 6836 I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I tem I

)	arderso	. 1		artment of Health and rtificate of Death	Mental Hygien	
	Physic /Medi		Karl J. Haders	1 Jerome Anderso	September	
9	Exami	ier	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Dea Baltimore	^	IC. County of Death
3	Funeral Director		5. Social Security Number  6. Sex 1 Dec Grant Park  6. Sex 1 Dec Grant Park  7. Age (In yrs. last birthday)  Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country) Louisiana
	r 28a-f show	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the a or 28a-	Direc	10e. Street and Number 905 Kevin RD.	10f. Zip Code		Citizen of What Country?
ဖွ	72 hours after death with the Maryland naturel", or Items 23a or 28a-f show dical Examiner must be routified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
215-0036	72 hours "naturel", dical Exa	eted by	3 Widowed 4 Provorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedency Give	1 Yes 2 No Specify:  dent's Usual Occupation kind of work done during most of wo	orking 16b.	Specify: Black Kind of Business/Industry
21	filed within Hygiene. Ither than "I	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Poli	CE OFFICER	(	City
Maryland	Mental Mental arked o	To Be	James Anderson	Katie	ame (First, Middle, Maide MOYE	,
	s 1 and 2 sho of Health and item 27 is my other traum		Schaswette Taylon - France 905	ng Address (Street and Number or F	Balto, mo	21229
Baltimore,	Page ent o nt: If y or			ention (Name of natory or other place)	-04 Cat	Onsville MD
Ball	permit. P Departm Importar agy injur		Joy 17 Wand Go	Name and Audress of Facility  No. P. March Fitt &		n Pass Ballo., ms
	Physician		23a. Part Fif the 1st ase, or complications that caused the death. Do not ent shock, or and failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Ethanol and heroin		ac or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):  Sequentially list conditions,  b.			
	be executed ician and burial-transit	Examiner	If any, leading to immediate cause. Line Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
8760,	sate phys	dical E	d			
.O. Box 6	death certifi e attending ed for use as	by Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	sign d be	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the ur Cocaine use	nderlying cause given in Part I.		use contribute to the cause of death?
al Records,	The law ate has be	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 \[ \] No
of Vital	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?  Yes 2 □ No  Hospital: 1 □ Inpatient 2 ☑ ER/Outpatien	t 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 ☐ Residence	
Division	anding F sath. or: After he funer	atlon		28c. Injury at Work?  P ^M 1 □ Yes 2 <b>X</b> No	28d. Describe how inju	
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  1 ☐ X Could not be determined  28e. Place of Injury - At home, tarm, strubuilding, etc. (Specify)  found at home	eet, factory, office	28f. Location (Street a City or Town, State Baltimore,	ng Mumber, Bural Boute Wumber, 9905 Kevin Kd. Maryland
	To the Hosp within 24 hou To the Funei completely fil	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  2 XMedicel Exeminer: On the basis of examination and/or invariant and manner stated.	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as stated. Indicates and due to the cause(s)
	To II To II	M	29b. Signature and title of certifier  Jasher Greenberg MD	29c. License number O.C.M.E.		ate signed (Month, Dey, Year) Ember 02, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, ITasha Z Greenberg H.D.	Print) 111 Penn Stree	et, Baltimon	ce, Maryland 21201
**.	Sta Registi		21 Date filed (Month Day Year) 22 Bodethe's Signature	had.		

			1 - For State Registrar	State of Maryla		artment of H rtificate of			iene •g. No2 () ()	L 28272
		9	Decedent's Name (First, Middle, Last	st)				2. Date of Deat	110 0 17	3. Time of Death
	Physici		Francis Xavier	Alagna				Septemb		004 6:00 PM
	/Medio		4a. Fecility Name (If not institution, give			4b. City. Town. o	or Location of Death	REPERTIE	4c. County of	
	Examir	ier	Ruxton House &		и Пото	Pikesv				altimore
7	Funeral		5. Social Security Number 6. S		. ITOITE	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		). Birthplece (State or Foreign Country)
3	Funeral Director			M 2□F 84		Months Days	Hours Min.	Feb. 8,	1920 I	Country) Maryland
A	pu ,		Usual Residence of Decedent  10a. State 10b. County	1100.0	Sh. Town and a					Last Clinias (1995)
	larylan show ad at	_			City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
Xavior	ath with the Maryle 23a or 28a-f shows ust be notified at	Director	Maryland Baltin	ore	Cator	nsville				
2	or 2	D L	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
10	ath v	Funeral	6032 Brunt Oak				228		U.S.	
	er de	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	s aft	byF	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ⊠Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specity:		Specify:	771
Frances 21215-0036	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or flems 23a or 28a-f show ther, the Medical Examinat must be notified at		15. Decedent's Ed	Year or Dates:	16a Dogg	dent's Usual Occur	anting		16b. Kind of Busin	White
2 5	n 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of worki	ing	IOD. KING OF BUSI	ness/industry
12 2	with ene. then	m	Elementary/Secondary (0·12)	College (1-4or 5+)		les	-,		Trans 0.1	
	be filed within 72 ho tal Hygiene. d other then "natur svent, me Medical	Ü	17. Father's Name (First, Middle, Last)		1 00	ITES	18. Mother's Name	(First, Middle, M	Trucl Maiden Sumame)	
2	d be antal ced o	o Be	Joseph Alagna				Frances	Culotta		
<u> </u>	2 should be filed within and Mental Hygiene. Is marked other then aumatic svent, the M	2	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura			ate. Zip Code)
≥	ith ar Ith ar 27 Is 1rau		Janis A. Little	(Daughter)		Sussex W				
Baltimore, Maryland	Hea Hea tem		20a. Method of Disposition		Place of Dispo	sition (Name of			ryland 2	
<u>o</u>	ages ant of t: If i		1 A Burial 2 Cremation 3 C 14 Donation 5 Other (Specific			natory or other pla	1	0.01		
圭	artme ortan injur		21. Signature of Funeral Service Licer				1 Gdns. 9-		Marriott	sville, MD
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic sy ODCe.		VR med	I found	Wi	tzke Fun	eral Home	of Cato	nsville,	Inc. ryland 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not ent	er the mode of dvir	ng, such as cardiac of	or respiratory arre	st.	Approximate
			shock, or heart failure. List only Immediate Cause (Final	Charles and Charles and Charles						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			Z DISBAS	E			3 weeks
	Examiner			Due to (or as a conse	quence or):					
<b>1</b>	M2	e.	Sequentially list conditions,	b. Dua to (or as a conse	quence of).					
	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	execun and and all tra	Exa	resulting in death) Last	CDue to (or as a conse	quence of);					
760,	ate be executed sysician and he burial-transit	cail		d						
89	ificati g phy as the									
×	leath certifici attending pl	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of	of delivery
ă	death atte	Clai	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	У		Month	
o.	t the de by the tached	Physiclan/Med	9 Unknown	9□Unknown						
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certifical riceath.  ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by P	Part II. Other significent conditions of	ontributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
rds	quire n sig	D D						1 🗌 Ye	s 2 No 3	Probably 4 Donknown
00	w requ	Completed						24a. Was ar	24b. We	re autopsy findings available
Re	The law ate has page 2 a	E						autopsy	y prio	r to completion of cause of the
[2]	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				OO Discount Description	1 ☐ Yes 2		Yes 2 No
5	ysician: is certific director,	0 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 [	TER/Outpation	t 3 DOA Cth	26. Place of Death		nce 6 □Other	(Canada)
ō	g Phy er this	<b>-</b>	27. Manner of Death	28a. Date of Injury	28b. Time of				w injury occurred	(Specify)
on	ding I th. : After s funer	Iţ.	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No			
18	Attendir death.	fica	3 Suicide 6 □ Could not be	286. Place of injury - At I	home, farm, str	eet, factory, office		28f. Location (Str	reet and Number	or Rural Route Number,
Ď	after after Dire	Certification:	4 Homicide determined	building, etc. (Spec	ify)			City or Town	, State)	
	spita hours nera / fille	a	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn	owledge, death	occurred at the tir	me, date and place, a	and due to the ca	iuse(s) and mann	er as stated.
	ne Ho 124 t ne Fu iletely	edical	(Check only 2 Medicel Exam one)	niner: On the basis of examinand manner stated.	ation and/or inv	estigation, in my o	ppinion, death occurre	ed at the time, da	ate and place, and	I due to the cause(s)
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licens				Month, Day, Year)
	. •		I wwoman fre	eue		H45	931	, L	Tepteml	her 7,2004
-			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)				
	$\mathcal{O}_{\mathbf{J}}$		Debirah Pierce	1220 PAKIC	- H2611.	S AVANT	A BATIN	MEMO	21208	
to the	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1. 11.				
	Registr		CED A R	711116 PTD	PE	1 Lang 4 1 1 3				

Churts Patzl
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Please	Type or Prin					•		-	
		For State	DATE TOTAL	State of Ma					vientai Hy	- 7	IOO	20272
		Hegistrar AM     Decedent's Name			n Go.	J 7400	MACHIOID!	Doutif	2. Date of D	Reg. No.	.004	3. Time of Death
Physicia		Charles		Ba	ker				Autus	+ Day	9 200	54 // = 40Pm
/Medic Examin		4a. Fecility Name (If	not institution, give	street and number)			4b. City, Town, o	r Location of Death	1)		County of Dea	ath
		Genesis	Elderca	are Cato	n Ma	nor	Baltim	ore	_	US	SA	
Funeral		5. Social Security No		x 7. Ag M 2□F		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)	9. Bir <i>C</i>	rthplace (State or Foreign ountry)
Director		213-84-	3955		42	Yrs.			9-25-	61_	MD	)
land ow		10a. State	10b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
Mary Ind	to	MD			Bal	timore	е					1∭Yes 2□No
th the	irec	10e. Street and Num	nber				10f. Zip Code			10g. Citi	izen of What C	ountry?
23a	a	1724 Dr	uid Hill				21217			USZ	A	
tems	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?			as Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whi</li> </ol>	
rs afte	by F	1 ☑Never Marrie 3 ☐ Widowed	ed 2 Married 4 Divorced	1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates:	No	1	□Yes 2 <b>X</b> No	Specify:			Specify: 💂	
2 hou			15. Decedent's Edu			16a. Decede	ent's Usual Occup	pation		16b. Kir	Blac	
hin 72	plet	(Speci Elementary/Secon	ify only highest grad	de completed) College (1-4or 5	5+1	(Give k	rind of work done O NOT use retire	during most of word)	king			,
giene giene	Completed		1047, (5 12)	15		Custo	dian			Clea	aning	service
d oth	Be	17. Father's Name (	(First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	
Men	2		oy Murr					Doris S				
12 sh and r is m			me/Relationship (T)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1		and Number or Ru				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exemities must be multiled at once.		Doris  20a. Method of Disp	Baker	(mother		1724		Iill Ave	Balt		d 2121 cation - City or	
nt of nt of n: If it		1 Surial 2	☐Cremation 3 ☐F		0	emetery, crem	atory or other plac					
artme ortsni injury			5 Other (Specify, neral Sept ce Licens	A	IMt.		Cemete	ery 9-3			to co	
permi Depa Impo any ir		1	enlow!	KAN	੍ਹ ਦੇ			cern Ave				
y y		23a. Part I. Enter th	ne disease or comp	lications that caused one cause on each li	the death						1100 21 2	Approximate
Physician		Immediate Cause (	Final V	one cause on arch in	100	mon	8					Interval Between Onset and Death
/Medical		disease or condition resulting in death)		a. Due to or as	a consequ	uence oj):						
Examiner		Sequentially list con	aditions	h	41	DS						
D #	iner	Sequentially list con if any, leading to im cause. Enter Under	riving	Due to (or as	a consequ	uence of):						
executed in and ial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L		c Due to (or as	3 0000000	uongo of):						
sician and burial-transit		,		,	a consequ	derice or).						
leath certificate be attending physici I for use as the bu	Physician/Medical		•	d								
certii nding use a	Z/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome						2	23d. Dale of de	livery
death e atte d for	clai	in the past 12 i	months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (s <i>pecify)</i>	·			Month	Day Year
by the	hys	9 🗆 Unknown		9□ Unknown								
res that the de signed by the a be detached f	by P	Part II. Other signifi	icant conditions co	ntributing to death b	ut not rest	ulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	o the cause of death?
w require been sig	ted								10	Yes 2	]No 3 ☐ Pi	robably 4 DUnknown
has be	Completed								24a. Was			utopsy findings available completion of cause of
The ate h	Con									ormed?	death? 1 ☐ Yes	-
cian: ertific ector,	Be	25. Was case referr examiner?	1.7	Manaital.			-	26. Place of Dea	th (Check only	one)		
Attending Physician: The er death. rector: After this certificate hat by the funeral director, page	7	1 ☐ Yes 28 1	NO	Hospital: 1 ☐ Inpatie 28a. Date of Inju		ER/Outpatient		4 Nursing H	ome 5 Resi			ecify)
ding h. After funer	ion	1 XNatural	5 Pending	(Month, Day	y Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
death death ctor: y the	ficat	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of Inj	urv - At ho	me. farm. stre		103 2 100	28f. Location /	Street and	d Number or R	ural Route Number,
after Dire	Certification:	4  Homicide	determined	building, et	c. (Specify	()	or, ractory, omoc		City or To	wn, State)	1	
spits nours neral		29a. Certifier	1 Certifying Phy	sician: To the best	of my kno	wledge, death	occurred at the tir	ne, date and place	, and due to the	cause(s)	and manner as	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	edical	(Check only one)	2∐ Medicel Exam	iner: On the basis of and manner sta	i examina	tion and/or inve	estigation, in my o	pinion, death occu	rred at the time,	date and	place, and due	e to the cause(s)
To t To t	Σ	29b. Signature and	title of certifier	116	)	h 60	29c. Licens	e number		29d. Date	e signed (Mont	th, Day, Year)
		- all	in t	Mens	170	11/500	RA D	5368	2	JEI	0. (	2004
		30. Name and addre	ss of person who c	ompleted cause of d	eath (Item	23a) (Type, P	rint) Prin	" Bli	d 30	3 F	3. Otn	2004 none 21259
Sta	te	31. Date filed (Mont	th Day Year)	2. Registr	ar's Signa	ture	· i cere		,	111		
Registr	_	SE	P 0 8 2004	Marie	, Do	6000	w					

			1 - State of Maryland / Department	artment of Health and M rtificate of Death		ene 2004 28274
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
H	Physici /Medio		Marion Lydia Brandt		09/06/	^{Day} Year 6:30 P ^M
>	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Calvert Hospice Foundation, Inc			Talbot
	Funeral Director		5. Social Security Number 220-07-7632 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 1 1 2 / 1 5 / 1	9. Birthplace (State or Foreign Country) VA
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary fed i	ō	MD Baltimo:	re		1, <b>25</b> Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	h with	0	1077 Wilmington Avenue	21223		U.S.A.
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - American Indian, Bleck, White, etc.
21215-0036	a within 72 hours after death with the Maryland Jiene. r than "natural", or Hems 23a or 28a-1 show The Micdical Examinar must be notified at	۵	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 😿 No	1 ☐ Yes 2 No Specify:	rioan, etc.)	Specify: White
2-0	72 ho	Completed		dent's Usual Occupation kind of work done during most of worki	ing 16	6b. Kind of Business/Industry
21	within one.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	Hygier Hygier Ither th			lephone Order C		iontgomery Ward
Maryland	ed ta b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)
Ë	d 2 should be th and Menta 7 is marked traumatic ev	ဥ	Russell Taylor  19a. Informant's Name/Relationship (Type, Print)  19b. Mailii	Edna Ma		City or Town State Zio Code)
Ma	12. har 7 is			54 Jarrell Road		
ē,	1 a Hegen		20a Method of Disposition 20b. Place of Dispo	sition (Name of		Oc. Location - City or Town, State
OIL.	8 = 5		1 M Burial 2 Cremation 3 Hemoval from State	d Cemetery 09/0	9/04	Millboro, VA
Baltimore,	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Licensee 23	2. Name and Address of Facility G.	J.Gonce	Funeral Home, PA
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not en			
	Priysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	malhypoxi	a	Interval Between Quset and Death
8760,	death certificate be executed eathording physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	espiratenzy t structive pulm	imary	distate years
Box 6		Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the ded by the destached		9 ☐ Unknown  Part II. Other significent conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did toba	cco use contribute to the cause of death?
ords,	law requires that the as been signed by th 2 should be detache	ted by	athroschosis, cardiác de	1srhythmia	1 ☐ Yes	2 No 3 Probably 4 Nown
Vital Records,	9 L B	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
of \	Physic this or	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		me 5 Residen	ce 6 Nother (Specify) Hospice
n c		inol	27. Manner of Death 1.★Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred
Sic	at :: e	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	29f Location /Stre	et and Number or Rural Route Number,
Division	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	eet, factory, office	City or Town,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)
	F S F 0		Isumon us	D57860	5	eptember 7, 2004
7	h		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		eptember 7, 2004 1, MD 21601
				wild Avenue	Eastor	, MD 21601
	Sta Registi	•	31. Date filed (Month, SEPar) 0 8 2004 32. Register's Signature			
			1	ASSESSED		

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	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  William Darnell Baker Jr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	2. Date of De Month Guqust	Day Year 3. Time of Death
	Examile Funeral Director		Stella Maris Hospice At Mercy Baltimo  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If		4c. County of Death  N/A  th (y, Year)  -47    Ac. County of Death   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position   Position
	death with the Maryland ims 23a or 28a-f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	consville)	10d. Inside City Limits 1X Yes 2 □ No
0036	e Ha	d by Funeral Director	1518 King William Dr. 21228	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: Black
Baltimore. Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than *natural; or its raumatic evant. In Medical Exercit.	Be Completed		ing most of working  3. Mother's Name (First, Middle,	tion Soc. Sec.Adminstra  Maiden Sumame)
Baker,	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "n any injury or other traumatic evant. Its Med. once.	To	19a. Informant's Name/Relationship (Type, Print)  Linda D. Baker Wife  20a. Method of Disposition  19b. Mailing Address (Street and 1518 King Will 20b. Place of Disposition (Name of		
Baltimo	permit. Page Department of Important: if any injury or once.		`4 Donation 5 Other (Specify) Garrison Forest	9-8-04 of Facility thers Funeral v Place, Balt	Owings Mills,Md.  l Ser,P.A. imore,Md. 21217
8760.		ilcal Examiner	23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
O. Box 68	ne death cer the attendin hed for use	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
Records. P.	w requires that the bear signed by should be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		obacco use contribute to the cause of death?  (es 2 No 3 Probably 4 Unknown
	sician: The law certificate has rector, page 2:	Be Completed		autop perfo	prior to completion of cause of death?  2 No 1 Yes 2 No
Division of Vital	ng Phys	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other.  27. Manner of Death 1 Ratural 5 Pending (Month, Day Year) 28b. Time of Injury at Work?	3 2 □ No	now injury occurred
Divi	To tha Hospital or Attandi within 24 hours after death. To tha Eunaral Director: A completely filled in by the ft	al Certifi	4 Homicide determined 298. Place of Injury - At home, farm, street, factory, onice building, etc. (Specify)  298. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, or	City or Tow	cause(s) and manner as stated
	To tha Ho within 24 th To tha Fu completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated.  29b. Signature and title of certifier  29c. License nu	on, death occurred at the time, of	date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	13		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Covid. Rischerg 301 ST PCW   P1	Baltimore,	8/31/2004 md. 21202
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 8 2004 September 19 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		

				For State Registrar	State of	Marylaı	nd / Depa		Health and N	Mental Hyg	_	n.	28276
		Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
		/Medi	cal	Folger Lee	Brooks	harl		4h O'h T		Septemb		2004	5:53 AM M
		Examir	ner	651 Keesey		oer)			or Location of Death Ville			ty of Death	
		Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birth	place (State or Foreign
		Director		215-32-2915	1 □ <b>X</b> M 2 □ F	68	3 Yrs.	Months Days	Hours Min.	Aug. 5,		Nort	th Carolina
		land ow		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
		Many B-1 sh	tor	Maryland Ceci	1	Pe	rryvil	le					1 ☐ Yes 2√∑No
5		or 28	Director	10e. Street and Number				10f. Zip Code		1	l0g. Citizen of	What Cou	ntry?
X		s 23a	rai	651 Keesey Lane				21903			USA		
0	(0	fter de r Itam inser	by Funerai	11. Marital Status 1 ☐ Never Married 2 💢 Marri	12. Was Deced Armed Ford ed 1 TYes 2	es? ! □ No			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes of No- Rican, etc.)		ice - Americ ack, White,	
Q	5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dieal Examinat must be notified at	d by	3 Widowed 4 Divorced	1 If Yac Givo	es: 1954	-57	1 ☐ Yes 2 📉 No	Specify:		Specii		hite
,	5-0	72 hours "natural", adical Exc	ietec	15. Decedent' (Specify only highes	s Education		16a, Deced	lent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind of B		
	2121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4	for 5+)		ector	a)		Aerospa	ace Ma	anufacturing
		be filed trail Hygie of other ovant, trail	Be C	17. Father's Name (First, Middle, L	_ast)		1110		18. Mother's Name				
	ylar	2 should be filed withir and Mental Hygiene. Is marked other than sumetic event, the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental th	ToE	Harvey Le	e B	rooks			Bertha		elle		lcomb
	Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationsh					and Number or Run				
9		of Health of Health litam 27 i		Ella S. Brooks  20a. Method of Disposition	- MTTG	20b.	Place of Dispo	sition (Name of	ne, Perry		MaryLar 20c. Location		
10	altimore,	Pages ent of nt: If it ry or c		1 Burial 2 □ Cremation 14 □ Donation 5 ☑ Other (Sp		ate		natory or other place.  Mem. Gard				1005	
B	alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at an 2018.		21. Signatura of Funeral Service L		11a		. Name and Addre		IcComas I	Tuneral	Home	aryland e. P.A.
	8	8 9 E 8		* HK/IXL	any				sbury Roa	d, Abina	gdon, M		
_				23a. Parf1. Enter the disease, or shock, or heart failure. List of	complications that can	used the dea ch line.	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Adj	anc	red (	0/61	Cance	<u></u>			10 years
		Examiner			Due to (o	as a consec	quence of);						/
		p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consec	quence of):						
		be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec	Tuence of):						
	Box 68760,	ate be execut nysician and he burial-trar	ical E		200.00	us a consec	querice or).						
	89	tificate ig physias the	ledic		d								
	30X	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		Ectopic pregnancy	,		1	ate of delive	•
	P.O. E	ne dea the at	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of o	death 5□	Other (specify)			Mic	onth	Day Year
	٩.	Attanding Physician: The law requires that the death certifica rideath. actor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it		Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to th	he cause of death?
	Vital Records,	requires been sign should be	ed by							1 □ Ye	s 2 No	3 ☐ Prob	pably 4 🗆 Unknown
	၀၁	e faw requir has been si je 2 should	Completed							24a. Was ar		Were auto	psy findings available
	- E	The page	Com							perform	ned?	death?	mpletion of cause of
	Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Death		de de		
H	of	ding Physician: The h. After this certificate h. funeral director, page	7; To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatient 28b. Time of	28c. Injun	er: 4 Nursing Ho	me 5 Reside 28d. Describe ho			v)
	ion	uttanding death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Day Year)	Injury		k? Yes 2 □ No				
	Division	or Attandutter death	Certification;	3 Suicide 6 Could not determine	286. Place 0	f Injury - At h , etc. <i>(Speci</i>	ome, farm, stre	et, factory, office		28f. Location (Str City or Town	eet and Numb , State)	er or Rura	J Route Number,
		spital ours a haral E		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	owledge death	occurred at the tra	no, data and place	and due to the ca			
		To tha Hospital or Attant within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medicai	(Check only 2 Medical E	xaminer: On the bas and manne	is of examina	ation and/or inv	estigation, in my o	pinion, death occurr	ed at the time, da	ite and place,	and due to	the cause(s)
		To the comp	ž	29b. Signature and title of certifier	$\mathcal{M}$	_		29c. Licenso	e number	29	9d. Date signer	d (Month, I	Day, Year)
		XI		1 Lame	110/	M		DI	7583	\$	eptem	ber	3,200V
		10,	8	30. Name and address of person v	no leted cause	of death (Iter	m 23a) (Type, I	Print)	8 Lay	STree		Í	212.
		Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature		MORNICIO	een, Pk	aryar	4	2101
		Registr	ar	SEP 0 8 2004	Sevente	- 15	So.	als			/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Kathryn Brewster 09 03 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

**Funera** Directo

**Physician** 

/Medical

**Examiner** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at 2008.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner	ir.
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
101	

	5. Social Security Number 6. Sex		t highdayl	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bi		Carroll	the lane (Ctate or Foreign
١.	373-24-0006	м 22 F 79	Yrs.	Months Days	Hours Mir		ay, Year	25 Mic	thplace (State or Foreign ountry) Chigan
	Usual Residence of Decedent	13				reb. /	17.	25 1110	.III.gaii
	10a. State 10b. County	10c. City,	Town or Loca	ition					10d. Inside City Limits
5	Md. Carroll	To 4	1 1	-					1 ☐ Yes 2 🔀 No
ect	Md. Carroll  10e. Street and Number	FI	nksbur	10f. Zip Code			10a C	itizen of What C	nuntry?
급		_ 3		· ·			-		out it y :
Funeral Director	2708 Appleseed Ro		10.14	21048	0.1-1-0	(O# - W N		SA	-dana ladia
l n	Tr. Maria States	12. Was Decedent Ever in U.S. Armed Forces?	IS. W	es, specify Cubar	n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Am Black, Whi	
×	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give - Year or Dates:	1 [	∃Yes 2XINo	Specify:			Specify:	Thi + a
D E	21		16a Dagada	at's House Ossums	tion		105		White
lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give ki	nt's Usual Occupa nd of work done d O NOT use retired)	uring most of w	orking	100. 1	Kind of Business	Andustry
Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) Yrs College S		Teacher			Edi	ucation	
S	17. Father's Name (First, Middle, Last)	IIS COILEGE D	CHOOL	reacher	18. Mother's Na	ame (First, Middle			
Be	George Teske				Bertha			,	
2	19a. Informant's Name/Relationship (Ty)	no Printl	10h Mailina				04	or Town Ctate	Ti- Code)
						Rural Route Numb			Zip Code)
	Elisabeth A. Brewst			Salem La	ne Bow	nie MD	207		Town Class
١.,	1 Burial 2 Cremation 3 R		netery, crema	tory or other place	a)	Date	200. L	ocation - City or	Town, State
	`4 □Donation 5 □Other (Specify)					4/2004	Ham	stead,	Maryland
	21. Signature of Funeral Service License	90	22. 1	Name and Address	s of Facility	11824 R	eis	terstown	Road
	samo	lun .	E1i	ne Funer	al Home	Reister	sto	wn, MD 2	21136
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.	Do not enter	the mode of dying	, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	MATASTATI	n. B4	PEART	CAOC	NOMA			Onset and Death
	resulting in death)	Due to (or as a conseque	nce of):	10/10/		1100/1/			Syenia
je.	Sequentially list conditions if any, leading to immediate	Due to (or as a conseque	nce of):						
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events								
Exa	resulting in death) Last	Due to (or as a conseque	nce of):						
by Physician/Medical Examiner		ı							
edic									
N S	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnanc						23d. Date of de	livery
clar	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of deat		ctopic pregnancy Other (specify)				Month	Day Year
ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		,,,,,					
P.	Part II. Other significant conditions con	tributing to death but not resulti	ng in the und	erlying cause give	n in Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
d b	CORONARY ARTE	RY DISEASE				10	Yes 2	! □ No 3 □ P	robably 4 Unknown
eted	11/020					-			
Comple	<del></del>					24a. Was auto	DSV	prior to	utopsy findings available completion of cause of
Ö						1 Tes	ormed?	death?	2 □ No
Be	25. Was case referred to medical examiner?			1.		eath (Check only	one)		
2	1 ☐ Yes 2 No		NOutpatient	3□ DOA Othe	r: 4 🗆 Nursing	Home 5 sesi	dence	6 ☐Other (Spe	city)
ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 2: (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how inju	iry occurred	
atle	2 Accident investigation			M 1 □ Y	es 2 □ No				
tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location ( City or To	Street a	nd Number or R.	ural Route Number,
Cer								,	
a	29a. Certifier Certifying Phys	sician: To the best of my knowle	edge, death o	occurred at the tim	e, date and place	ce, and due to the	cause(s	) and manner a	s stated.
Medical Certification:	one)	ner: On the basis of examination and manner stated.	n ariuvor inve	sugation, in my op	migh, death occ	Juneo at the time,	date an	u piace, and due	o to the cause(s)
Ž	29b. Signature and title of certifier			29c. License	number			ate signed (Mont	
1	(Speil lu	n		D2	8987		q-	- 3-2	ve 4
	30. Name an inddress of purson who co	mpleted cause of death (Item 2	3a) (Type, Pr	int)					
1		UD SEAL IN			- 0	1100	MA	2/22	0

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 8 2004

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

CHARLES HARRISON

29a. Certifier

(Check only one) 29b. Signature and

Medicai

completely

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6001 MUNCASTER MILL ROAD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DØØ41218

29d. Date signed (Month, Day, Year)

ROCKVILLE, MD

				State of Maryland / Department of Health and M	Anntal Hygiana
			1 - For State Registrar	Certificate of Death	0001 00000
			Decedent's Name (First, Middle, Las		Reg. No. 3. Time of Death
	Physici /Medi		Marvin	Derkowitz	3eptember 4 2004 14:55 M
	Examir		4a. Facility Name (If not institution, give	e street and number)  4b. City, Town, or Location of Death	4c. County of Death
		N.		okins Hospital Baltimore	N/A
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign Country) MA
	D		Usual Residence of Decedent	, J2	077 007 1332 MA
	arylar show	_	10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	the M.	Director	MD MONTGOME  10e. Street and Number		1 □ Yes 2√√ No
	With With	Dir	25115 VISTA RIDGE	ROAD 106. Zip Code 20882	10g. Citizen of What Country?
	death ma 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (So	
9	after or Ite		1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 No  If Yes, specify Cuban, Mexican, Pueric  If Yes, Give  1 ☐ Yes 2 No Specify:	WUTTE
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f show the Macifical Examiner must be motified at	d by	3 Widowed 4 Divorced	Year or Dates:	орозну.
15	in 72	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)  (Give kind of work done during most of work life, DO NOT use retired)	ting 16b. Kind of Business/Industry
212	filed with Hygiene. other ther	mo:	Elementary/Secondary (0-12)	5+ ATTORNEY	LAW
	be filed ital Hygie d other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Sumame)
yla	should be nd Mental marked o	To	HENRY	BERKOWITZ NATHALI	E KATZ
Maryland	01 02 20 00		19a. Informant's Name/Relationship (7		al Route Number, City or Town, State, Zip Code)
	1 and 2 Health		KATHERINE BERKOWI  20a. Method of Disposition	20b. Place of Disposition (Name of	LAYTONSVILLE, MD 20882  Date 20c. Location - City or Town, State
10L	Pages nent of i int: If It		W☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State cemetery, crematory or other place)	Total Total on Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total of Total
Baltimore,	그 든 뿐 글		21. Signature of Funeral Service Licen		7/2004 RANDALLSTOWN, MD LEVINSON & BROS., INC.
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-			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac one cause on each line.	or respiratory arrest, Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition resulting in death)	* Intracerebral hemor	rhage Onset and Deeth
В	/Medical Examiner		resoning in death)	Dye to (or as a consequence of):	0
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Leukemia	
0,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of):	
8760,	9 × e	dicai	(	d.	
x 68	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy	
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
0	at the de by the	hysi	9 Unknown	9□ Unknown	
s, P	The law requires that the ste has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Record	w require been st				1 Yes 2 No 3 Probably 4 Unknown
ec	e law re has be	Completed			24a. Was an autopsy findings available prior to completion of cause of
_		S			performed death?  1 Yes 2 No 1 Yes 2 No
Ø	<u>;</u>		25. Was case referred to medical	26. Place of Death	n (Check only one)
Vital	sician: Th certificate irector, pag	o Be	examiner?	Hospital: 10 Descript 20 FB/Output 20 DOA Other.	
of	Physician: this certific ral director,	To B	examiner? 1 Tyes 2 No - 27. Manno of Death	28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
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of	Hospital or Attending Physician; 4 hours after death. Funeral Diractor: After this certific lely filled in by the funeral director.	edical Certification; To B	examiner?  1 Yes 2 No -  27. Manno of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Yes 2 No -  1 Pending investigation determined	28a. Date of Injury 28b. Time of Injury at Work?  Normalize to Injury 28b. Time of Injury at Work?  Normalize to Injury - At home, farm, street, factory, office building, etc. (Specify)  Specials: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)  and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
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of	r Attending Physician: ter death. iractor: After this certific h by the funeral director.	Medical Certification; To B	examiner?  1	28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  29c. License number  29c. License number	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)  and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Nd.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year SEPTEMBER 3, 2004 Physician BRISKMAN 7:40 P LEA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth Month Day, Year) JUNE 13,1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F 114-28-3508 90 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f ehow 1 Yes 2 No Director MONTGOMERY ROCKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 6121 MONTROSE ROAD 20852 USA filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🎇 No WHITE Specify: δ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked of Be **GERTMAN** DAVID ETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health ar Important: if item 27 Is eny injury or other trau CYNTHIA ROSNER / DAUGHTER 1620 E. JEFFERSON LANE #324 - ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🎇 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MT. NEBO-KENDALL MEMORIAL 9/7/04 MIAMI, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCHEMIC CARTHOMYOPATHY /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NELIMONIA Due to (or as a onsequence of): Examiner Due to (or as a consequence of) igned by the attending physician be detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? (es 2) No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 27660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ospital suburban 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2004

BRISKMAN, LEA

Amend item# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Phy (883), 9/14/04 TI State of Maryland / Department of Health and Mental Hygiene 1- State Registrament ITEM #19b PER INF. G835 9715/04 fit Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dana Alan Chapman Month Dav Year **Physician** Dana Allan 2004 September 5 8:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6620 Washington Boulevard Lot 1 Elkridge Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. Director 179-50-5365 41 June 15, 1963 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6620 Washington Boulevard Lot.1 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give² Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INS Civil Consultation 12 Customer Service Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ronald Chapman Beverly Henderson ဥ 19b. Mailing Address (Street and Number of Rugat Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Chapman - Wife 6620 Washington Blvd. Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/9/04 Fork Cemetery S. Fork, Pennsylvania ' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home At MMP., Inc. M. Hah 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial disease or condition resulting in death) nour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last transit The law requires that the death certificate be executed burial-t Due to (or as a consequence of): Box 68760. nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ad by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. s been signal Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 2 No To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death Check on one examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide illed 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 29c. License number September 7, 2004 50338 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia MD, 21044 Little Patuxent 11055 32. Registrar's Signature State Registrar

Baltimore, Marylan	permit. Pages 1 end 2 should be
	Ph /I Ex
	petno

		Please Type or Print in Black indelible Ink. Assure State of Maryland / Department of Health an		ile.
		AMEND ITEM #7 PER FH G835 9/08/04 Continued of Death	Reg. No. 0	4 28282
	Physician /Medical	1. Decedent's Name (First, Middle, Last)  CHADARA VINIECE, CURTIS	2. Dete of Death Month Dey SEPTEMBER 3, 20	3. Time of Death Year 004 1443 PM
	Examiner	4e Fecility Neme (If not institution, give street end number)  4b. City, Town,	or Location of Death 4c. County o	f Death
	Funeral Director	5. Sociel Security Number 6. Sex 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Months 1 Pays Hours 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pays 1 Pa		9. Birthplece (State or Foreign Country)  M  D
	Maryland  -1 show  The case	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD N/A BALTIMORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	iter death with the Mai r theme 23s or 28s-f si closer must be notified Funeral Director	10e. Street end Number 10f. Zip Code 21229	10g. Citizen of Wi	hat Country?
5-0036	by Vd	If Yes, Give ' 1 ☐ Yes 20/3 No Specify: Year or Dates:	? (Specify Yes or No- uerto Rican, etc.)  14. Race Black  Specify:	- American Indian, , White, etc.
21215-0	be filed within 72 hor tal Hygiene. d other than "natura event, the Medical B	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  A  College (1-4or 5+)  A  College (1-4or 5+)		iness/Industry
Maryland	Mental Hyg Mental Hyg arked other atic event,	17. Fether's Neme (First, Middle, Last) VINCENT G. CUITIS  18. Mother's CINAV	Name (First, Middle, Maiden Sumame Hell Session	)
	i 1 end 2 sho Health end Iam 27 is m other traum	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	. Apt. I. Baltir	
Baltimore,	permit. Pages Depertment of Important: If its any injury or o	1 B Burial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)	109.09.04 BAUTIN	
m E	A S E S A		NATIL PIKE BALL	
	Physician /Medical			Onset and Death
ı	Examiner	Immediate Ceuse (Final disease or condition resulting in death)  a. Total bowel necros some pure to (or es a consequence of):		
	acuted and trensit	Sequentially list conditions,  Sequentially list conditions,  Due to (or es e consequence of):	<u>-</u>	1 days
Ö,	a a a a a a a a a a a a a a a a a a a	if eny, leading to immediate		2 months
Box 68760,	The law requires that the death certificate be assisted has been signed by the attending physician errors as should be detached for use as the buriel-theory of the properties of the buriel-theory of the physician medical Ex	that initieted events resulting in death) Last  Due to (or as a consequence of):  d.		
P.O. B	t the death by the atte tached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	ribute to the cause of death? 3 Probably 4 Unknown
Hecords, I	equires the	RESpiratory failure	24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause
	S 25 D		10 Yes 2 10	of death?
of Vital	certification in a Be	25. Was case referred to medical examiner?  1	Death (Check only one)	(Carrita)
on of	To the Hospital or Attanding Physician: The is within 24 hours after deeth.  To the Funeral Director: After this certificate ha completaly filled in by the funeral director, paga.  Medical Certification: To Be Com	The res 25 to Transaction 2 ENVolution 3 DOA 4 Nursin	g Home 5 Residence 6 Other 28d. Describe how injury occurred	
Division	tal or Attanding Pirs after deeth.  al Director: After tiled in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number City or Town, Stete)	r or Rural Route Number,
	o the Hospit ithin 24 hour ompletaly fille	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end process of examiner on end/or investigation, in my opinion, death cone) end manner steted.	ccurred et the time, date end place, er	nd due to the cause(s)
	~ /	29b. Signature and title of certifier  29c. License number	29d. Date signed	(Month, Dey, Year)
•	18	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)	PEPTENO	21215
_		David Kanter, M.D. Sinai Hospital 2401 W. BE	duedere Balti.	more, md
	State Registrar	and a discount of the second of		

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ORIGINAL

			1 - State Amend Item 8 Registrar	State of Mar per fh G84!	yland / E 5 <b>7-1</b> 5-	epartment of I Certificate of	Health and <i>Death</i>	Mental Hyg	iene •g. NQ:	22202
	Physicia		1. Decedent's Name (First, Middle, Lass FRED Ct	O, SR				2. Date of Death	, Day Yeer	2. Time of Dealth
	/Medic Examin Funeral Director		241-20-0°PM	meral 1	HOSPIT In yrs. last bird 83	ol Bulti	MUTE  If Under 24 Hrs  Hours Min	th  C/ Ly  S. Date of Birth	4c. County of Det	th A thplace (State or Foreign ountry)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  N/A	1	10c. City, Town	or Location ALTIMOR	e.			10d. Inside City Limits 1   1 Yes 2   □ No
	h with the 23a or 28	<b>Funeral Director</b>	10e. Street and Number	rica Ave	enue	10f. Zip Code	1225	10	0g. Citizen of What C	ountry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland H tiam 27 la marked other than "naturel", or Itama 23a or 28a-f show or other traumatic event. The Medical Examiner must be notified at	by Funer	11. Marital Status  1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 Styles 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: 2	
21215-0036	d within 72 ho giene. Ir than "natu	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wo	rking	16b. Kind of Business	
CCO Maryland	2 should be filed with and Mental Hygiene. I a markad other that raumatic evant, ILET	To Be C	17. Father's Name (First, Middle, Last) LAWIZENCE	ceo			18. Mother's Na	me (First, Middle, N	Aaiden Sumame) AHAM	
	1 and 2 sho Health and 1 am 27 la me		19a. Informant's Name/Relationship (7)			Mailing Address (Street	1	,	City or Town, State,	,
$\mathcal{M}_{\mathcal{U}}$ Baltimore.	Pa Intrine		20a. Method of Disposition 1		20b. Place of cometer.	Disposition (Name of y, crematory or other pla 21500 FORE			20c. Location - City or OWING-S M	
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service Licen	liam		22. Name and Addre VAUSHN ( SIST PALT	ass of Facility GREENE	FINERAL ATIL PIKE	L SERVICE, BALTO M.	S D21229
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only disease or condition resulting in death)	a. Due to (or as a c	coiny	ustinal	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
8760.	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditi						
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of Vit	Phyaiciar this certif al directo	To Be	25. Was case referred to medical examiner?  1 Yes 20 No  27. Maryner of Death		2 ER/Out	patient 3L DOA	ner: 4 ☐ Nursing H		nce 6 Other (Spe	cify)
Division of Vital Records, P.O	To tha Hospital or Attending Phyaician: within 24 hours after death.  To the Funaral Diractor: After this certific completely filled in by the funeral director,	Certification:	2 Accident Suicide 4 Homicide Pending		- At home, far	ijury Wo	ry at rk? Yes 2 □No	28d. Describe how 28f. Location (Stru- City or Town,	eet and Number or Ru	ural Route Number,
L	To the Hospitel of within 24 hours at To the Funeral Completely filled in	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of r liner: On the basis of ex and manner state	xamination and	death occurred at the tile.	me, date and place	e, and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier	etata		29c. Licens	9501	29	9/1/04	h, Day, Year)
			30. Name and address of person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person who of the person	SPENUTO	t, ///.	Type, Print) ()	Maryl	and 6	reneral	Hospital
- 1	Sta Registra		31. Date filed (Month, Day Year) 8	2004 See	Signature	house				/

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Month 09/04/2004 Physician 12:00P M Joseph William Cosgrove /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1230 Hillcreek Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/13/1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1**X** M 2□ F Months 62 Director 220-38-8785 MD Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If itam 271s marked other than "natural", or Items 23a or 28a-1 ahow ury or other traumatic avant, the Medical Exam and rematic avant, the Medical Exam and rematic avant. 1 ☐ Yes 2 🛣 No Director Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1230 Hillcreek Road 21122 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator General Motors 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas J. Cosgrove Elizabeth Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cosgrove/Wife 1230 Hillcreek Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury of once. `4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cem 09/08/04 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -UNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PYLMOWIRY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed EMPHY SEMA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy WAVE MYUCARAIR 2 No NON D 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide , 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smallwd Rd. Pasadena Md21/22 Jarah Dr. Michae 32. Regis 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryland / Dep.	artment of Health a rtificate of Death	ind Mental H	lygiene Reg. NG.		28285
			1. Decedent's Name (First, Middle, Last	)		2. Date of		Vana	3. Time of Death
и	Physici /Medic		Thomas M. Crok	ce		August	'	2004	1:001
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of	f Death	4c.	County of Death	
			Ruxton Manor Car	e	Towson			Baltimon	re
	Funeral		Social Security Number     6. Se		If Under 1 Year If Under 2 Months Days Hours				place (State or Foreign ntry)
	Director		216-72-7625	M 2□ F 79 Yrs.	Months Days Hours	August	1,19	25 Mary	yland
	ם ,		Usual Residence of Decedent	10. 01. 7					
	anyla shov	_	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	8a-f	cto	Maryland Baltimo	ore Balt	imore				1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g. Citiz	zen of What Cou	ntry?
	ath w	ra	7215 York Road	-	21212		-	U.S.A.	
	er de teme	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	gin? (Specify Yes or I , Puerto Rican, etc.)	No- 1	<ol> <li>Race - American Black, White,</li> </ol>	
36	s afte	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:			Specify: Whi	1 + 0
21215-0036	hour tural	be be	15. Decedent's Edu		dent's Usual Occupation		10h Ki-		
<u>.</u>	n 72 "na	Completed	(Specify only highest grad	(Give	kind of work done during most DO NOT use retired)	of working	TOD. KII	nd of Business/In	idustry
2	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	I/A			N/A	
0	Hygin Hygin sther		17. Father's Name (First, Middle, Last)		·	r's Name (First, Midd	lle, Maiden .	<u> </u>	
an	d be ental ked c	To Be	Authur G. Croke		A1	lice S. An	derso	1	
Maryland	should be filed within 72 hours after death with the Maryland and Manalla Hygiene. Hygiene "narked other than "natural" or Items 23a or 28a-f show marked other than "natural" or Items 12a or 28a-f show matic event. Ite Mardical Examples Invest Let notified at	1	19a. Informant's Name/Relationship (T)	ype, Print) 19b. Maili	ng Address (Street and Number				Code)
S	ith ar ith ar 27 is r trau		Joseph Anastasio	·	York Road Bal				· ·
ē,	Hea Hea tem		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date		ation - City or To	
2	ages int of t: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	nemoval from State	matory or other place)	0 7 2004	D 1	- 11 - 16	1 1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Health and Hygiene.  Department of Health and Hygiene.  Department of Health and Hygiene.  Department of Health and Hygiene.	i	21. Signature of Tuneral Service Lines	1 /2 2	art of Jesus    2. Name and Address of Facility	,		alk, Ma	
Ba	Depa Depa Impo any ir		VX barred	Lanceles Wi	tzke Funeral H 30 Edmondson A	lome of Ca	tonsy	ille, In	IC.
			23a Part1. Enter the disease, or some	lications that caused the death. Do not en				e, Maryı	Approximate
١.,			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	. * 0	i. O.	6		Interval Between Onset and Death
	mysician /Medical		disease or condition resulting in death)	a. Heure Ma	carchal.	man	1100	1	1 day
	Examiner			Due to (or as a consequence of):					
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequence of).		0.5			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. ,					
_	ate be executed hysician and the burial-transit	Kai							
9	clar	niii .	that initiated events resulting in death) Last	c					
9	- 5	alE	triat initiated events						
68760,	ficate be executed physician and s the burial-transit	edical E	triat initiated events						
ox 6876	certificate I nding physi use as the t	√Medical E	resulting in death) Last	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy			2	3d. Date of delive	erv
Box 6876	leath certificate I attending physi I for use as the b	cian/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		2	3d. Date of delive	ery Day Year
.O. Box 6876	the death certificate I y the attending physi iched for use as the t	nysician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		2		
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			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death	7
	Physici		Month Day Year	м
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	-
1	Exami	iei	St. Agnes Hospital Baltimore	
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	Director		216-54-6687  1 M 2 F 53  Yrs. Months Days Hours Min. (Month, Day, Year) 5/30/1951  MD State of Poletics (State of Poletics) 5/30/1951	
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	within 72 hours after death with the Maryland ane. then "naturel", or Itams 23a or 28e-f show ta Medical Exar. herr sast kerrofilied at	Funeral Director	2610 Turf Valley Rd. 21042 U.S.A.	
	ter de	nu.	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married  1 □ Yes 2 ▼ No  12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
36	irs aff	by F	2 Nideward A Discood If Yes, Give 1 □ Yes 2 No Specify: Specify:	
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
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	al Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, I'e Ms	2	John Schwing Anna Taylor	
an	2 sho and I s ms		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 and 2 Health tem 27		Paul Hlubb - Companion 2610 Turf Valley Rd. Ellicott City, MD 21042	
Baltimore,	50		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  20c. Location - City or Town, State	
Ë	permit. Pages Department of I Importent: If it any injury or o		'4 □Donation 5 □Other (Specify) Gien Haven Cemetery 9/3/2004 Gien Burnie, MD	
Salt	permit. Depart Import any inj		21. Signature of Funeral Service Licepose 22. Name and Address of Facility Witzke Funeral Home of Catons-	
	₫ O Œ 6 0		ville 1630 Edmondson AVe. Catonsville, MD 2122	3
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition a. Metastatic lung Cancer Non-Small all 5 mas	
	/Medical Examiner		resulting in death)  Due to (of as a consequence of):	_
		L.	Sequentially list conditions, b	
1	ed isit	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	
_	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
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Вох	atter I for u	Physician/M	in the past 12 mopules?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year	
P.O.	tt the de by the a tached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	
	res that igned b be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
rds	quires n sign		1 Yes 2 No 3 Probably 4 Unknow	1
Ö	w requ	Completed	24a. Was an 24b. Were autopsy findings available	
Re	The lav	mc	autopsy prior to completion of cause of performed? death?	
Vital Records,		Ö	1 ☐ Yes         2 ☐ No         1 ☐ Yes         2 ☐ No           25. Was case referred to medical         26. Place of Death (Check only one)	
	Physician: this certific ral director,	0.0	examiner?  1   Yes 2   No	
of	g Ph er thi	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	-
jo	Attending I death. ctor: After y the funer	atio	1 ☑Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Division	of or Attencafter death	tific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Ō	s after s Direct	Certification:	building, etc. (Specify)	
	Hospitel or Attending 44 hours after death. Funerel Director: After tely filled in by the funer		29a. Certifier (Check only only only only only only only only	
	To the Hospitel of within 24 hours at To the Funerel D completely filled is	Medicai	and marrier stated.	
	7 × 10 CO CO CO CO CO CO CO CO CO CO CO CO CO	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
,			MCCON P44243 Md August 31, 2004	
	11.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SWCock IV MO 1120W. Ralling Rd Catmaille MW 21228	
	Sta	te.		
	Registr	-	31. Date filed (Month, Day, Year)  SEP 0 8 2004  32. Registrar's Signature	

				1 - For State Registrar	State of	f Marylar	nd / Depa	artment rtificate			nd Me		jiene	004	28287
		Physici	an	1. Decedent's Name (First, Middle, La							2	. Date of Dea Month	th Day	Year	3. Time of Death
		/Medic		MILDREI		LARKE						higust	31	2004	1:30 AM
		Examir	ner	4a. Facility Name (If not institution, give						Location of		U		ounty of Death	100=
				FRANKLIN SQUAK		7. Age (In yrs.		If Under 1		F DAL	_	Date of Birth			
		Funeral Director			1□M 2 <del>Q</del> F	93		Months	Days		Min.	. Date of Birth (Month, Day 7 / 8 / 1	Year)	Coul	place (State or Foreign htry)  MD.
~		D.		Usual Residence of Decedent				1				., 0, 1			
3		Maryland -f show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo							[ ]	10d. Inside City Limits
BROWN		ath with the Marylar s 23a or 28a-1 show	ecto	MD. BALT	.O.		R	OSEDA					0. 02:		1 ☐ Yes 2√2 No
20		₽ 5	ក់	5401 LITAN	IV TANE			10f. Zip (		237		1	log. Citize	n of What Coul	ntry ?
9			Funeral Director	11. Marital Status	12. Was Dece	dent Ever in L	J.S. 13.	Was Decede			n? (Speci	fy Yes or No- can, etc.)	14	. Race - Americ	can Indian,
7	9	or Ite	F	1 Never Married 2 Married	Armed For 1 Tes If Yes, Giv	2 No		lfYes,speci 1 □ Yes 2		n, Mexican, Specify:	Puerto Ri	can, etc.)		Black, White,	
MILDR	21215-0036	n 72 hours after de "natural", or Item edical Examinal	d by	Widowed 4 □ Divorced	Year or Da	ates:		1 105 2	ΓΑΓΙΝΟ	эреспу.			5	pecify: BL	ACK
7	<u>.</u>	n 72 t "nati	iete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done d	tion uring most o	of working		16b. Kind	of Business/In	dustry
2	12	iene. r than "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		OMEST					PRI	VATE 1	FAMILY
		i Hygi other	BeC	17. Father's Name (First, Middle, Last						18. Mother's	s Name (/	First, Middle, I			
外	/lar	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I've Ma	To B	EDWARD JE	NNINGS						SAR	AH	BRC	WN	
AXXE	lan	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (									-	own, State, Zip	
4	2 ⊘	1 and Health em 27 ther tr		PAMELA PERKIN	IS	206	540.			LA.				. 2123	
7	altimore, Maryland	to to		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐		State	cemetery, cre	natory or oth	ner place		Dat			tion - City or To	
	これ	permit. Pag Department Importent: I any Injury o		' 4 ☐Donation 5 ☐ Other (Special Signature of June 21. Signature of June 221. Signature of June 221.			DRUID	RIDG Name and			/4/0	4	PIK	ESVILI	LE, MD.
	Ba	Departing Departing Important Irraportant		I feel G	Ste	2/		FSTE	PEB		ĘŲNE	BALLH	OME	P.A 2121	1.7
		- 1		23a. Part1. Enter the disease, or com	plications that ca	aused the dea	th. Do not ent	er the mode	of dying					. 212	Approximate
		Pnysician	8 1	shock, or heart failure. List only Immediate Cause (Final disease or condition	_	EUMON	IA-								Interval Between Onset and Death
		/Medical		resulting in death)	w	or as a consec									
	Ø	Examiner		Sequentially list conditions,	b										
		ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or if july	Due to (	or as a consec	quence of):								
		cate be executed obysician and the burial-transit	хап	that initiated events resulting in death) Last	cDue to (	or as a consec	quence of):								
	8760,	e be e rsiciar	dical E	· · · · · ·	d										
1	9	certificate nding physise as the	ledic												
	Вох	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnirth 2 Peta		Ectopic pre	anancv				230	d. Date of delive	•
		0 0	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ant at time of d		Other (spe						Month	Day Year
Ì	P.0	by ac		Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying ca	use alve	n in Part I	-	23e Did tob	Dacco use	contribute to th	ne cause of death?
	ds,	es og	d by	GI BLEED	John Dating to Go	201001101101	soung in the a	idenying car	use give	iriir aici.		1 🗆 Ye	14	No 3 ☐ Prob	
	Sor	> 0 10	Completed				_					24a. Was a	. /	24b Wara auto	psy findings available
1	Re	The law ate has b page 2 si	ш		·							autops perforr	y ned?	prior to con death?	npletion of cause of
	ta	iclen: Th certificate rector, pag	Be Co	25. Was case referred to medical						26 Place 0	I Death //	1 Yes 2	2 X No	1 🗆 Yes	2□ No
	>	Physiclen: this certific ral director,	To B	examiner? 1 □ Yes 2 🂢 No	Hospital: 1 💢 ir	npatient 2	ER/Outpatier	t 3 DOA	Othe					Other (Specifi	()
P	0			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28	c. Injury Work			d. Describe ho			,
	Sio	Attending r death. sctor: After oy the fune	catl	2 Accident investigatio 3 Suicide 6 Could not b				М		es 2□No					
	Division of Vital Records,	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	4 Homicide determined	286. Flace	of Injury - At h ng, etc. <i>(Speci</i>	iome, larm, str fy)	eet, lactory,	office		281	City or Town	reet and h n, State)	Number or Rura	I Route Number,
(		spitel ours a nerel [		29a. Certifier 12 Certifying Pl	vsicien: To the	hest of my kno	owledge death	n occurred at	t the time	date and	nlace and	1 due to the ca	auco(c) an	d mannar ac el	atod
		e Hos 24 h e Fun letely	edical	(Check only 2 Medical Examone)	miner: On the ba and mann	isis of examina	ation and/or in	vestigation, i	n my op	inion, death	occurred	at the time, da	ate and pl	ace, and due to	the cause(s)
		To th within To th compl	Me	29b. Signature and title of certifier	11/	7/1		29c.	License	number		25	9d. Date s	igned (Month,	Day, Year)
	)	/		Jan 1	Sal	kas		D	00	604	153	4	Jane.	£31	2004
		h		30. Name and address of person who	completed cause	e ol death (Iter						A	7		
				Dr. ANASTASIOS.		strar's Signa		KLIN S	Quf	KE DA	4 VE	BACTI	MORE	-, MD	21237
		Sta	ite	31. Date filed (Month SEP ead 8	2004	Journal & Signi	aiuia	brook	1						

		1 - For State Registrer		State of M	iai yiai iC		rtificate			7 IAIGUL		g. No.	004	28288
Obronia		1. Decedent's Nam	ne (First, Middle, La	ast)							ate of Death	Day	Year	3. Time of Death
hysic= Medi/		Di	iane	V		(	Collin	ns			GUST	31	2004	11:29
Exami		360	1	ve street and number			10		Location of De	eath	,		ounty of Dea	
		G080 -	>AMARIT		PITAL	-		- , , .	If Under 24 F	las I		DI		NORE
neral ector		5. Sòcial Security I  212-58-2  Usual Residence of	2696	4 CT 14 OFF	ige (In yrs. Ia 53	Yrs.	Months	Days	Hours M	in. (A	ate of Birth fonth, Day, 4–1–5]	Year)		thplace (State or Fore puntry) Id.
7		10a. State	10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Lim
event, the Medical Examiner must be notified at	to	Md.	NA			Balt	imore	2						X Yes 2□
To a	Funeral Director	10e. Street and Nu	ımber				10f. Zip	Code			10	g. Citize	n of What Co	ountry?
4	a D	115 E.	Melrose	Ave.			2.	21211	•			U	SA	
	ner	11. Marital Status		12. Was Deceden Armed Forces		13.	Was Decede	dent of His	spanic Origin? n, Mexican, Pu	(Specify Y	es or No-	14	. Race - Ame Black, Whit	
8	F		ried 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 Yes 2		Specify:	0,10 1,1041.	, 5.5.,	5	pecify:	6, 010.
4	d by	3 X Widowed	4 Divorced	Year or Dates:	:								В	lack
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된	Completed	Elementary/Sec		College (1-4or	5+)		er Wo					N	7.	
ent, I		12th g 17. Father's Name	rade (First, Middle, Las			116	/EL WO	1	18. Mother's N	lame (Firs	t, Middle, Ma			
Cev	To Be	Charle	s		Howard	l, Sr.			Beati	cice			Ste	wart
TE EL	-	19a. Informant's N	lame/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Number or	Rural Rou	te Number,	City or 7	Town, State,	Zip Code)
other traumatic	1	Crystal	Thompson	n Daugh	ter	9407	7 Harc	rest	Way, I	Perry	Hall	Md	. 21	128
otu		20a. Method of Dis	sposition		20b. Pla	ce of Dispo	osition (Nam	ne of		Date			ition - City or	
Š		1X Burial 2 14 □Donation	Cremation 3	Removal from State	9		maiory or on							
			5 ⊟Other (Speci	ify)	Ga	arden	of Fa		1	7-04		Bal	timore	, Md.
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State Registrar

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

GAURAN KHANNA GOOD SAMARITAN HOSPITAL, BALTIMIRE, MD

31. Date filed (Month, Day, Year)

SEP 0 8 2004

SEP 0 8 2004

SEP 0 8 2004

RES 000

August 31,2004

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M.D

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** Carpenter Edna Willie 8 31 2004 1947 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner J.H.H. Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 214-16-6983 Director 96 N.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28a-1 show other treumatic event, the Medical Examinar must be positived as 1X Yes 2 □ No Funeral Director Baltimore NA Md. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 959 N. Washington St. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩idowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygens Importent: If Item 27 Is marked other the any injury or other treumatic event, Ital. 2010. 7th grade Laundry Bugler Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robinson Maggie Usher Richard ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 Harwood Rd, Edgewood, Md. Coretha Johnson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-4-04 Md. Nat. Mem. Pk. , Md. Laurel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the demandance, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AHTOUR least /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Be Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 1 ☐ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DU059300 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rst. Butmore 1000 31. Date filed (Month, Day, Year) egistrar's Signature State SEP 0 8 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	for State	State of Ivial	-	-	lealth and Men	tal Hygie	ne	
aion I	Registrar  1. Decedent's Name (First, Middle, La		. 1	Certificate of	2. [	Reg. Date of Death Month	No. Year	3. Time of Dea
cian lical		harles	Dutc	hman	524	otember	1,2004	
iner	4a. Facility Name (If not institution, gin			1 17	r Location of Death		4c. County of Death	1
	5. Social Security Number 6.	Sex 7. Age (	In yrs. last birth			Date of Birth Month, Day, Ye	9. Birth	nplace (State or For
r	163-28-9492 Usual Residence of Decedent	1√2 M 2□ F	65 Y	rs.				nsylvania
_	10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Lin
Funerai Director	Maryland  10e. Street and Number		Ba1	timore 10f. Zip Code		100	Citizen of What Cou	1 Yes 2
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nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.		dispanic Origin? (Specify an, Mexican, Puerto Rical		14. Race - Amer	ican Indian,
	1 Never Married 2 Married	1√∑Yes 2 No		1 ☐ Yes 2√☐ No	Specify:	11, 610.)	Black, White	nite
ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates: 1		Decedent's Usual Occup	agtion	106	. Kind of Business/li	
piet	(Specify only highest gr Elementary/Secondary (0-12)			Give kind of work done life. DO NOT use retire	during most of working d)	,	, Kind of business/ii	ndustry
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2	Wilbur Fink	(Time Britan)	405		Ruth Franc			
1	19a. Informant's Name/Relationship				and Number or Rural Ro			
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	> MSK. HO	edeman		Gary L. Kan	afman Funera	1 Home	At MMP.,	Inc.
	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do no	ot enter the mode of dying	ng, such as cardiac or res	piratory arrest,	<del>ige, nary</del> i	Approximate Interval Between
1	disease or condition	Infe	etion					2 days
	resulting in death)	Due to (or as a	consequence of	):	1			()
	Sequentially list conditions,	b. End 5	ons in nea of	Liver D	isease			
Examiner	Sequentially list conditions, for y local policy cause. Enter Underlying Cause (Disease or injury that initiated events			,-				
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cian/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2		3 Ectopic pregnancy	,		23d. Date of deliv Month	rery Day Year
nysician/M		1 ☐ Live birth 2   4 ☐ Pregnant at tin 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _				*
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Dan Br Prysician D0057459 8/29/04	the f	icati	3 ☐ Suicide 6 ☐ Could not t	De Glans of Init	IIn/ - At ho	ome form etr			28f Location /	Street and Nu	nhar or Pur	Al Pouto Number
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Double of account who completed cause of death (term 23a) (Type Brief)	D	icai C	(Check only 2 Medical Exa	miner: On the basis of	f examina	wledge, death tion and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and i date and place	nanner as s e, and due to	tated. o the cause(s)
Doos 1459 of actions of across who completed cause of doath (from 23a) (Type Print)	Funeral L	77		7 4	7 2 '		29c. Lice	nse number		29d. Date sign	ned (Month,	Day, Year)
30. Name at address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles Stree	completely filled	Med	29b. Signature and title of certifier	/ / /								
	to the Funeral C completely filled	Med	29b. Signature and title of certifier	n/ f	hysic	ian	D	20574.	59	8/2	9/04	

			1 - For State Registrar		of Marylan	_	artmen <i>tificat</i>					Reg. No	m m ~ 1	2.8	292
	Physici /Medic			· DE	Nisu	K					2. Date of D Month	ber	5 - 26	64 11	e of Death-
	Examin	er	4a. Facility Name (If not institution, Howard County G						Location o t Cit				:. County of De Howard	ath	
	Funeral Director		5. Social Security Number 220–20–9398	6. Sex 1 <b>万</b> ≰M 2□ F	7. Age (In yrs. <b>7</b>	last birthday) 3 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D May 2			Country)	ate or Foreign
	the Maryland 28a-f ahow notified at	ector	Usual Residence of Decedent  10a. State  MD  Howard  10e. Street and Number	đ		y, Town or Lo						10a Ci	itizen of What	10	e City Limits Yes 2 No
	th with 23a or	al Dir	9518 Westwood Di	rive				2104	2		:	_	ed Stat		
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ia marked other than "naturel", or Items 23a or 28a-f ahow any injury or other traumetic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	2 □ No ve		Was Deced f Yes, spec 1 ☐ Yes		panic Orig n, Mexican Specify:	jin? (Spec , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh Specify:		n,
21215-0036	within 72 h ene. than "natu he Wedica	Completed	15. Decedent (Specify only highes  Elementary/Secondary (0-12)		1-4or 5+)	1	kind of wor DO NOT us	rk done di se retired)	tion u <i>ring m</i> ost	of workin	g		Kind of Busines		
	uid be filed fental Hygi rked other tic event, I	To Be Co	12 years 17. Father's Name (First, Middle, I Steven Denisuk	.ast)		Meat	Mana				(First, Middle te Dre	e, Maidei	,	_ore	
, Maryland	and 2 should salth and Mer n 27 ia marke ser traumetic		19a. Informant's Name/Relationsh David Yancosky	nip (Type, Print)	son	9518	West	wood				-	or Town, State		
altimore,	Pages 1 ment of He tent: If iten jury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	pecify)	State	Place of Dispo emetery, cren View C	remat	ther place Ory		epter 7, 20	004	Balt	ocation - City o	City,M	o <b>.</b>
Bali	permit. Page Department i Importent: If any injury or		21. Signature of Funeral Service L	C. C	mel	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	name an Onnel 110 S	d Address ly Fi ollei	of Facility Inera Inera Inera	l Hor int l	me Of Road,	Dund Dund	alk,P. <i>H</i> alk,Md.	1	
	Physician /Medical Examiner		23a. Pant. Enter the disease or shock, or heart failure. Vist of Immediate Cause (Final disease or condition resulting in death)	a. <u>COI</u> Due to	JGE STI	VE C	ARD	TAC	Arms.	î L U		arrest,			mate Between nd Death WZEY &
,	cate be executed shysician and the burial-transit	Examiner	Sequentially list conditions, if any, toading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. Co	ARDIO (or as a conseq Ro NAF (or as a conseq	27 A	2TER		Dis	ens	E			Je	ay.
68760,	ficate be e p physiciar is the buri			(a. H.	TREET	15 % 31	2 ~	-				_	_	₹	ربنود
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live t	tcome of pregna birth 2 Feta nant at time of do own	I death 3	Ectopic pro						23d. Date of d Month	elivery Day	Year
	w requires that been signed t should be det	by	Part II. Other significant condition	ns contributing to d		ulting in the ur	nderlying ca	ause givei	n in Part I.				use contribute		
Vital Records,	: The law recate has be page 2 sho	Completed					_						prior to death?		gs available of cause of
of	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investig	28a. Date (Mon	Inpatient 2  of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury		A Other 8c. Injury Work	- 4 □ Nur	sing Hom	Check onl : e 5 ☐ Resi 3d. Describe	idence	6  ☐Other (Sp ry occurred	ecify)	
Division	el or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury - At ho ing, etc. <i>(Specif</i> )	ome, farm, stre	eet, factory	, office		28	3f. Location ( City or To		nd Number or F a)	Ru <i>rai R</i> oute N	lumber,
	To the Hospitel or within 24 hours after To the Funeral Dirticompletely filled in 1	edical	29a. Certifier 1 S Certifying (Check only one) 1 Medical E	Physician: To the exeminer: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, deat	d place, ar h occurred	nd due to the d at the time,	cause(s date and	) and manner a d place, and du	is stated. le to the caus	Θ(S)
1	To To To Com	M	29b. Signature and title of centifier  N. B. C.  30. Name and address of person of N. B. VE LLANK	llet			290.	License	3024	.69	S	29d. Da	ite signed (Mor	5 - Z	004
1	0						2ive	#1	00,	elk	TTD	city	. MD	210	42.
• 2.	Sta Registr		31. Date filed (Month, Day, Year)  SEP 0	8 2004	legistrar's Signa		hail.	,							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:05 P 6,2004 Demchur Trene reptember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Center Sougre Hospita Losedale 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) September 14,1926 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☑ F 278-28-5022 77 Yrs. Director I'N. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show :7 is marked other than "natural; or Items 23a or 28a-f sh traumatic event, the Modical Expendient mat be notified 1 Yes 2000 **Funeral Director** Baltimore Sparrows Point MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 Ross Avenue 21219 USA ges 1 and 2 should be filed within 72 hours after death v t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lyllian Mathis Joseph E. Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5934 Woodbine Road #57, Woodbine, Md. 21797 Judy Vrablic Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) September St. Andrews 10, 2004 Dundalk MD. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician evere /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate ba executed burial-transit Due to (or as a consequence of the attending physician ned for use as the buria Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 mor Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown à signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed page 2□ No 1 Yes 20 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 2 2 No 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D0056296 CUM who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MO, 21237 sirn baum 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2004

DHMH 17 Rev 1/2001

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ORIGINAL

Gladys Davis 04-05678 RPD

D	, 0	•	For Unpend Item State Registrar	2943270fpM4		ntificate of			ene g. No.2	1. 20001
	Physici	20	1. Decedent's Name (First, Middle, Li	ast)				2. Date of Death		3. Time of Death
	Physici /Medic	al	Gladys			Davis		Septemb	per 1, 2	0600Р м
	Examin	er	4a. Facility Name (If not institution, gi Johns Hopkins Ho	,		Baltimo	r Location of Death		4c. County of NA	Death
23,5	Funeral Director		226-32-3616	4 THA OFFICE	(In yrs. last birthday) 85 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	rear)	Birthplace (State or Foreign Country)  Va.
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Marylan -f show fied at	ţō	Md.	JA	Balt	imore				1 X Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
	th wit	alD	1243 N. Patterso	on Park Ave	•	2121	L3		US.	A
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eraminar must be notified a once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
ŏ	2 hou	ted	15. Decedent's E			dent's Usual Occup		. 10	6b. Kind of Busir	
215	hin 7	Completed	(Specify only highest gi	rade completed)  College (1-4or 5-	life.	kind of work done of DO NOT use retired	during most of work d)			,
21	ogiene er th	Son	7th grade			nestic			Other P	eople Homes
pu	al Hy d oth	Be (	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
<u>yla</u>	Ment Ment arket atic e	ပ္	Thomas		Grubb		Lottie		Gru	
, Maryland 21215-0036	and 2 shi salth and n 27 is m er traum		19a. Informant's Name/Relationship Geneva Ferguson	(Type, Print) Daugh	ter 19b. Maili	ng Address <i>(Street a</i> 243 N. Pat	and Number or Rui tterson P	al Route Number, o ark Ave.,	City or Town, Sta Baltim	ore, Md. 21213
ore	of He of He if item		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [	Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	(e)	Date 20	0c. Location - Cit	y or Town, State
Ĕ	Pag ment ant: I		`4 □Donation 5 □Other (Spec		Mt. Car	mel Cem.	9–8-	-04	Dundalk,	Md.
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Lice	Wan	N Cae	2. Name and Address March F.H.	. East	1101 E.		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to one cause on each line	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	_a Atheros	clerotic (	Cardiovas	cular Dis	ease		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		<u>.</u>	Sequentially list conditions,	b. — Due to /er ee e	annongues of					
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as a	consequence of):					4
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
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687	tificate ig physias the			d						
P.O. Box	ne death cer the attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
σ.	that the the the the the the the the the th	Ph	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
ds	lures n sign	d by						1 ☐ Yes	2 No 3[	□ Probably 4 □Unknown
Records,	w requir s been si should	lete						24a. Was an	24b. Wer	e autopsy findings available
Re	The lav	Completed					-	autopsy performe	prio	r to completion of cause of th?
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26 Place of Deat	10 Yes 2 E h (Check only one)		Yes 2□ No
>	Physician: this certific al director,	To B	examiner? 1X Yes 2 □ No	Hospital: 1 Junpatien	t 2 ER/Outpatier	nt 3 DOA Othe	or	me 5 Residen		Specify)
Division of	Attending Ph ar death. ector: After th by the funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury Work		28d. Describe how		
Ö	endir sath. or: Af he fu	Certification:	2 Accident investigation	on			Yes 2 □ No			
Ξ	or Att	tific	3 ☐ Suicide 6 ☐ Could not 8 determined		ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number o	or Rural Route Number,
0	ital c rai D led ir									
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medica	29a. Certifier 1 ☐ Certifying P (Check only one)  Certifying P  Company Medical Example (Check only one)	hysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	· ·		29c. License			_	fonth, Day, Year)
	2		Yamele & Just	hall MO		O.C.M	1.E.	S	eptembe:	r 2, 2004
	W M		I WALLE ! ZUANI	MAN LIVE						
5	of you	JI.	Describe F Ka	completed cause of de	ath (Item 23a) (Type,	111 Penn	Street,	Baltimore	, Maryl	and 21201

			For 1 - State Registrar	State o	of Marylan			t of H	ealth a			_	) 4	282	95
	Physici		Decedent's Name (First, Mill     RUTH	ddle, Last)			DΔ	NSIC	KED		2. Date of Deat Month SEPT.	h Day	Year 004	3. Time o	f Death
	/Medic Examin		4a. Facility Name (If not institu	tion, give street and nu	mber)				Location of		JLF I .	4c. County			
			11 SLADE AVEN	NUE APT. #4	15			ESVI				BALT	MORE		
	Funeral Director		5. Social Security Number 216-16-2801  Usual Residence of Decedent	6. Sex 1 □ M 2 ☐ F	7. Age (In yrs. <b>83</b>	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours		8. Date of Birth 07/05/1	921	9. Birth Cou	place (State of intry)	or Foreign
	/land		10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	ocation						1	10d. Inside C	ity Limits
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21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel" or items 23e or 28e-1 show event, I'v. Medical Exar in wringst be treitlind at	by	1 □ Never Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 🛣 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Marri	Armed Fe larried 1 ☐ Yes	orces? 2 🏹 No ve	)	If Yes, spec		Specify:	, Puerto F	cify Yes or No- lican, etc.)		ck, White		
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Maryland	should be nd Mental marked o umatic eve	To Be	CHARLES  19a. Informant's Name/Relation			FRIE		/C11-	RI	CA				СОНЕ	N
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F			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that dist only one cause on d	each line.				g, such as	cardiac or	respiratory arre	st,		Approximat Interval Bet Onset and I	ween
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Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		DEctopic pre	anancv					e of deliv	ery	
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	res that I	by Ph	Part II. Other significant cond	itions contributing to d	eath but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use conti	ibute to t	he cause of d	eath?
ord	w require been sig should b	ted t									1 ☐ Ye	s 2 🗆 No	3 ☐ Prot	oably 4 🖫	nknown
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Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:				0#-			(Check only one	d.			
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	m		30. Name and address of person					R.	testo	. A A	10				
	Sta Registr		31. Date filed (Month, Day, Yes	25 Man 8 2004 32	Registrar's Signa	ture	200	· · · ·	, rus Nou	<u> </u>	<u>د</u> ـــ				
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			1 - For State Registrar	State of Maryland / [		of Health and M	•	e	28296			
	Physici		1. Decedent's Name (First, Middle, Last)	woth			2. Date of Death Month D	ay Year	3. Time of Death			
	/Medic Examir		4a. Facility Name (If not institution, give str	reet and number)		wn, or Location of Death		c. County of Deal	th			
	Funeral Director		5. Social Security Number  218-18-0637  Usual Residence of Decedent	7. Age (In yrs. last bir	thday) If Under 1 ' Yrs. Months D	Year If Under 24 Hrs. Pays Hours Min.	8. Date of Birth (Month, Day, Yea July 27, 19		thplace (State or Foreign buntry) West Virginia			
	Maryland a-f show	tor	10a. State 10b. County  Maryland How	10c. City, Tow	n or Location	Ellicott City			10d. Inside City Limits 1 ☐ Yes 2 No			
	with the	al Direc	10e. Street and Number 4641 Woodland Rd.		10f. Zip Co	21042	10g. C	citizen of What Co	ountry? .S.A.			
980	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-f show ta Madrell Examiner must be notified at	Completed by Funeral Director	11. Marital Status 12  1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes _ 2 No If Yes, Give Year or Dates:		t of Hispanic Origin? (Spe Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:				
21215-0036	init. Pages 1 and 2 should be filed within 72 ho artiment of Health and Mental Hygiene. ortant: If Itam 27 Is marked other than "natur njury or other traumatic event. It is Micital 8.	ompleted	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tition 16a. College (1-4or 5+)		Occupation done during most of worki retired) Housekeeping	ing 16b.	Kind of Business/ Cleaning /	Industry Housekeeping			
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)  Benjamii	n Shipe		18. Mother's Name	's Name (First, Middle, Maiden Surname) Pearl Gertrude Richie					
	and 2 sho lealth and m 27 Is mu har trauma		19a. Informant's Name/Relationship (Type Ms. Helen Hamrick	p, <i>Print)</i> 19b  Daughter		treet and Number or Rura  ock Circle Westm			"ip Code)			
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any njury or othar tr once.		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Rer  4 □ Donation 5 □ Other (Specify)		r place)	Pate 20c. I	Location - City or Marriottsvi	Town, State ille, Maryland				
Balt	permit. Pag Department Important: any njury c		21. Signature of Funeral Service Licensee	er Mo1293	Sla	Address of Facility ack Funeral Home 71 Old Columbia	e, P.A. Pike Ellicott Cit	v. MD 2104	3			
	Enysician /Medical Examiner		23a. Part1. Ester the disease of complications, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	SETTLC  Due to (or as a consequence	of):	f dying, such as cardiac c	er respiratory arrest,		Approximate Interval Between Onset and Death			
8760,	ite be executed ysician and he burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of	INFECT		itingm	.(A	2 WEEKS			
P.O. Box 68	00	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	t. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 □Ectopic pregi 5 □ Other (speci			23d. Date of deli Month	ivery Day Year			
	w requires that been signed b should be deta	by	Part II. Other significant conditions contr	FAIWRE		e given in Part I.			the cause of death?			
I Records,	The lar ate has page 2	Completed	COROTANY ANT			UTIPUS	24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of			
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:		26. Place of Death						
of	ding Phys h. After this funeral dir	n: To	27. Manner of Death	spital: 1 Inpatient 2 ER/Ou 28a. Date of Injury 28b. T	Time of 28c.	Other: 4 Nursing Hor	ne 5 Residence 28d. Describe how inju		ify)			
Division	Itan Jeat tor: the	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) In 28e. Place of Injury - At home, fa	njury M	Work? 1 □ Yes 2 □ No	206 Location (Charles	and Nilmahara and Oi				
Di	or for filer		4 Homicide determined	building, etc. (Specify)			28f. Location (Street a City or Town, Stat	е)				
	To the Hospital within 24 hours a To the Funeral C completely filled i	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knowledge r: On the basis of examination and and manner stated.	, death occurred at t d/or investigation, in	he time, date and place, a my opinion, death occurre	and due to the cause(sed at the time, date an	i) and manner as id place, and due	stated. to the cause(s)			
	To t To t	M	29b. Signature and title of certifier	, som wo	29c. L	cense number 36974	29d. Da	ate signed (Month	, Day, Year)			
	10		30. Name and address of person who com	pleted cause of death (Item 23a) (	(Type, Print)	DOWNER BAR	mo 21	544	1			
*	Sta Registr		31. Date filed (Month, Day, Year)  SFP 0 8 2004	Registrar's Signature	books	, pricoc Brot	YENY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year FOREIT 505 RICHARD AUGUST 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimur .

If Under 1 Year | If Under 24 Hrs.

Days | Hours | Min. Hopkin NIA 170501 TRI 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F PENNSYLVANIA 141-48-5542 Yrs. 50 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No DE KENT DOVER 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? APT. 19904 10 FAIRWAY LAKES DR. B - 13USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 SQYes 2 □ No If Yes, Give Year or Dates I ETNAM 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CONSTRUCTION CHIMNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RICHARD F. FOREIT, ROSEMARY LAVALLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19904 19a. Informant's Name/Relationship (Type, Print) MARGARET ANN PALMERE FOREIT 10 FAIRWAY LAKES DR. APT. B-13 DOVER, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition DELWARE VETERANOS 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State * 4 ☐ Donation 5 ☐ Other (Specify) 9/9/04 MILLSBORO, DELWARE CEMETERY MEMORIAL 21. Signature of Funeral Service Licensee RACZOROWSK FaciliFUNERAL HOME P.A. DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL MULTIPLE 7 DAYS Due to (or as a consequence of) Sholli Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). insulficiency BPINATURY that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 1 Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

000 61871

29d, Date signed (Month, Day, Year)

SEPTEMBER

BALTIMORF MO 21201

requires that the death certificate be executed Records, P.O. Box 68760 The law Division of Vital or Attending Physicien: **Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

238

"naturel", or iteme

permit. Pages 1 end 2 should be filed within 72 hours after Department of Heelih and Mental Hygiene. Importent: If tiem 27 ie marked other than "naturel", or ite any injury or other treumatic event, the Madical Exemina

Physician /Medical

Examiner

attending physicien and for use as the burial-translt

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After this certificate has

death. Director:

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Examiner

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Completed

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29b. Signatur

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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other treumatic event, the Madical Examiner must be notified at

within 24 hours after To the Funerel Dire

31. Date filed (Month, Day, Year) SEP 0 State Registrar

0 8 2004

218 INONTH CHACLES STEEDT APT 2504 32. Redstrar's Signature

MO

30. Name and ard ress of person who completed cause of death (Item 23a) (Type, Print)

			1 - For Registrar	State	f Marylan	-	artment o			ental Hygi	ene 9. No ² () () ()	
	Physici	an	Decedent's Name (First, Middle							Date of Death     Month	Day Yea	
	/Medio	cal	Dorothy T. Fow.  4a. Facility Name (If not institution,		mher)		4h City Tow	n, or Location	of Doath	Septembe	er 5, 200	
Н	Examir	ner	1804 Wickes Ave		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		40. Oity, 104	Balti				I/A
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ar If Under		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		216-36-0570	1 □ M 2 💢 F	64	Yrs.	WOILIIS DE	110013	IVIII.	Sep. 28	1939	Maryland
	ow ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-fsh	to	MD 1	N/A			Ba1	timore				Yes 2□No
	or 28	Director	10e. Street and Number				10f. Zip Cod			10	g. Citizen of What	Country?
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_	r item	Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Fo	orces? 217 No	l l			n, Puerto F	cify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc.
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7	filed within 72 Hygiene. Ither than "nate ont, It a Medic	dmo	Elementary/Secondary (0-12)	College (	1-4or 5+)		omemake				Ota	n Home
פר	be filled tal Hygi d other	0	17. Father's Name (First, Middle, L	ast)			omemare		er's Name	(First, Middle, M		II Home
<u>Z</u>	should be ind Mental s marked umatic ev	To B	William B. Tul	Ly				Doro	othy	R. Reed		
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationsh								City or Town, State	
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I're Medical Examiner must be notified at		Teresa Lindaue: 20a. Method of Disposition	r Daught	20b. P	lace of Dispo	sition (Name of			100	e, MD 21	
ē	0 0		1 Burial 2 □ Cremation  * Donation 5 □ Other (Sp		State Mo	rerano	Menori Park		9-9-2	,	arkville	
Baltimore,	permit. Pag Department Important: I any injury o		21 Signature of Himeral 8	Mary 1	XI la	M 22						f Lansdowne
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			23a. Part T. Enter the disease, or shock, or heart failure. List of	inly one cause on	each line.						st,	Approximate Interval Between Onset and Death
- 11	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Mit	stake.	10150	-ull Cti	1/ung	can	cv		205 years
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	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	ience of):						
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200	certificate Iding phys			0							I	
X Q Q	th cer tendin or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna pirth 2 - Fetal		Ectopic pregna	incy			23d. Date of d	
	he death the atten thed for u	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Prega 9□Unkn	nant at time of de own		Other (specify,				Month	Day Year
<i>T</i> .	w requires that the death certifics been signed by the attending pt should be detached for use as t		Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the ur	nderlying cause	given in Part I.		23e. Did toba	cco use contribute	to the cause of death?
ecords,	quires an sign	ed by								1 DYes	2 □ No 3 □	Probably 4 Unknown
ပ္	60 60	Completed								24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	ysician: The law Is certificate has b	Соп								performe		?
VITAI	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			-57	04		(Check only one)		
0	Phy this	I=	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	-	ER/Outpatien 28b. Time of	1 3 DOA	4∐ Nu njury at Vork?		8d. Describe how	ce 6 Other (Sp injury occurred	pecify)
	endin sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investig	ation	in, Day (ear)	Injury		Yes 2 1	No			
UNISION	or Att fter de Directi	Certification;	3 Suicide 6 Could n 4 Homicide determin	288. Place	of Injury - At ho ing, etc. (Specify	me, farm, stre	et, factory, offic	се	2	8f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
_	spital ours a neral (		29a. Certifier 1 Certifying	Physicien: To the	best of my kno	wledge, death	occurred at the	time, date and	d place, as	nd due to the cau	se(s) and manner	as stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical E	xeminer: On the b	asis of examinat ner stated.	ion and/or inv	restigation, in m	y opinion, deal	th occurre	d at the time, date	e and place, and de	ue to the cause(s)
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	- T		· Ch M	W			1	2278	۷	5	3 tender	8,2004
	10		30. Name and address of person v	Loran M	se of death (Item 3d	23a) (Type, I	th KG	nover s	Weet	- Balt	neve Mus	2,2004 pland 21225
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 200	32. F	legistrar's Signa	draw!					,	,

DHMH 17 Rev 1/2001

			For Stete Registrer	State of Maryland	d / Departm <i>Certific</i>				giene Reg. NO 1 1 1.	20000
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		Floyo	1		2. Date of De. Month September	ath Day Yee	3. Time of Death
	Examin  Funeral  Director	er	223-34-4163	ng & Rehab.	E	lico nder 1 Year	tt City If Under 24 Hfs. Hours Min.	8. Date of Bin (Month, Da	y, Year)	aath  Birthplace (State or Foreign Country)
	death with the Maryland ims 23a or 28a-f show	eral Director	Usuel Residence of Decedent  10a. State  10b. County  MD. Howard  10e. Street and Number  8832 Tamar Dr. Ap  11. Marital Status	Colu		. Zip Code 21045	dispanic Origin? (S		10g. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 No  Country?
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examinant Instal Le indifficed at	Completed by Funeral	1 Never Married 2 Married    Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes,  1 Tye  16a. Decedent's  (Give kind of life. DO No.)	specify Cubins 2 X No Usual Occup f work done of use retired	an, Mexican, Puert Specify:  pation during most of word  Mana	king	Specify:Af  Ameri  16b. Kind of Busines	rican rican .can .ss/Industry
ryland 2	2 should be filed vand Mental Hygie and Mental Hygie Is marked other taumatic event, L.	e	12 17. Father's Name (First, Middle, Last) Sherman Hawkins 19a. Informant's Name/Relationship (Ty,	pe, Print)	Seamstr		Dryclean 18. Mother's Nar Lillie	ning ne (First, Middle, B. Hen	Dryclean Maiden Surname) adricks er, City or Town, State	
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is: any injury or other trau		Panya Blake/daug  20a. Method of Disposition  1 □ Burial XX remation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	hter  20b. Proceedings of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the proces	1412 A. lace of Disposition emetery, crematory t/Wash.	Stre (Name of or other place Crema e and Addre	et, S.E. 9/08 atory	Apt.4 3/2004 zke Fu	Wash D 20c. Location - City of Laurel, neral Ho	.C.20003
8760,	Medical Examiner and physician and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		SCLENOTUS  Jence of):  L  Jence of):  L  Jence of):  D  Jence of):	mode of dyir	ng, such as cardiad	or respiratory ar		Approximate Interval Between Onset and Death
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al Reco		e Completed	25. Was case referred to medical					1 ☐ Yes	prior to death'	
Division of Vital Records,	ling Physicii After this cer 'uneral direct	To B	evaminer?	ospital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3[ 28b. Time of Injury	DOA Oth	A Nursing H	ome 5 ☐ Resid	dence 6 □Other (Sp now injury occurred	necify)
Divis	i Sir e	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	"			City or Tov		
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medicel Examilate)	ner: On the best of my knowner: On the basis of examinat and manner stated.	wledge, death occu tion and/or investiga	ation, in my o	ppinion, death occu	rred at the time,	date and place, and d	ue to the cause(s)
	To with	Σ	29b. Signature and title of certifier			D 3	0641		29d. Date signed (Mo. September	
_	5		30. Name and address of person who co Dr. Ramesh 3000	North Ridge	e Road,	Elli	cott Ci	ty, Md.	21043	
	Sta Registi		31. Date filed (Month, Day, Year) <b>SEP 0 8</b> 2004	32. Registrar's Signal	don't					

		For State Registrar	State of Ma			nt of He	alth and M	lental Hyg	iene g. No. 2 / /	71. 2000
Physicia /Medic	al	1. Decedent's Name (First, Middle, La Leonard H. Fink, 4a. Facility Name (If not institution, gin	III		4b. Cib	y, Town, or L	ocation of Death	2. Date of Deat Month August	Day	3Time of Death Year 004 10:20 P
Examin Funeral Director	ier	607 Braeside RD  5. Social Security Number 6.1 213-36-5944	Sex 7. Age	(In yrs. last bi			ore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/02/1	Year)	A  9. Birthplace (State or Foreig Country) MD
Maryland a-f ehow	ctor	Usual Residence of Decedent		10c. City, Tow	vn or Location  Balti	more				10d. Inside City Limit
s 1 end 2 should be tiled within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number  607 Braeside RD  11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Dec		21229 panic Origin? (Sp , Mexican, Puerto <i>Specify:</i>			- American Indian, , White, etc.
vithin 72 hounne. ne. han "naturel" e Medical Ex	Completed b	15. Decedent's E (Specify only highest gi Elementary/Secondary (0·12)	Education rade completed) College (1-4or 5	+)		vork done du use retired)	ring most of work	ing	16b. Kind of Bus	
should be filed withir nd Mental Hygiene. s marked other than umatic event, Ita M	To Be Co	12 17. Father's Name (First, Middle, Las Leonard Henry Fir			Graphic		8. Mother's Nam	e (First, Middle, M	Maiden Sumame	
ss 1 end 2 sho of Health and N item 27 Is ma other traums		19a. Informant's Name/Relationship  Mary Joan Fink/W  20a. Method of Disposition			b. Mailing Addre  507 Brae  of Disposition (N  ery, crematory of	side	RD Bal	a <i>l Route Number</i> timore, Date	MD 2122	_
permit. Pages Department of H Important: If its eny injury or of		1 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Service Lice	ity)		athedral	Cem.	09/0	2/2004 wab Fune		ore, MD
Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	a.	the death. Do	not enter the m	ode of dying	such as cardiac	Baltimor or respiratory arm e UKEV	est,	Approximate Interval Between Onset and Death
Ite be executed with the burial-transit and burial-transit and	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence						
w requires that the death certificate to been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat	h 3 ⊟Ectopic 5 ∏ Other {				23d. Date Mon	of delivery th Day Year
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The la ate has page 2	Completed								pried? de	fere autopsy findings availab for to completion of cause of path? Yes 2 No
To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  Natural 5 Pending investigate	Hospital: 1  Inpatie 28a. Date of Inju	ry 28b.	Outpatient 3 Time of Injury M	28c. Injury Work	4 Nursing Ho	th (Check only on ome 5 Reside 28d. Describe ho	ence 6 Othe	
vital or Attenurs after deat	Certification:	3 Suicide 6 Could not determine	28e. Place of Inj building, et	c. (Specify)				City or Town	n, State)	r or Rural Route Number,
To the Hosk within 24 hor To the Fune completely fi	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	Physician: To the best aminer: On the basis of and manner sta	examination a	ind/or investigati	on, in my op 29c. License	nion, death occur	rred at the time, d	ate and place, a	(Month, Day, Year)
110		30. Name and address of person wh	o completed cause of d	eath (Item 23a	) (Type, Print)	1	Sas Que B		MUREN	M31787
St. Regist	ate	31. Date filed (Month, Day, Year)	AG2	ar's Signature	- 1 -					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** 4:25pm Follin Sept.6,2004 Bertha E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Stella Maris Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 15, 1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 ☐ M 2 ☐ XF 89 218-03-4889 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumstic event, the Madical Examinar must be multified at Middle River 1 ☐ Yes 2X No MD Baltimore Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with 140 Cowhide Road 21220 USA death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) House of Worster al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Presser 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Clifford Robinson Nettie Stroll 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tret once. Bryant Follin /son 17A WarrenLodgeCourt Cockeysville MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GardensofFaith 9/9/04 Rossville MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Essex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 anne 23a. Part1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GASTRIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clistass or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🛣 No Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident death. М 1 ☐ Yes 2 ☐ No after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Regignar's Signature State 0 8 2004 Registrar

DHMH 17 Rev 1/2001

SEPTEMBER 6, 2004

BERTHA FOLLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Austin Franklin Foland 9:45 p August 29, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Ye Jun 30, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Days Mary Land 1 X M 2 □ F 214-10-5453 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanti set must be notified at Frederick 1X Yes 2 □ No Maryland Frederick Directo 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 21701 290 Dill Avenue death 1 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 □ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Concrete Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Foland Rickerds Frank Ivy Harry 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Ronald F. Foland/ Son 332 West College Terrace, Frederick, MD 21701 other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Sep 2, 2004 Frederick, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentee Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 Approximate shock, or hearffailure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIFFICLE approx. 3wa **Physician** CLOSTRIDIUM COLITIS /Medical Due to (or as a consequence of). **Examiner** DISEASE PULMOPHARY CHRONIC OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed ROISUFFE BILATERAL PLGURAL Due to (or as a consequence of): Box 68760. attending physician Physician/Medical ATRIAL FIBRILLATION the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an GENERALIZED EDEMA DEPENDENT HYPERTENSION ANAEMIA 1 Yes 2 No. funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Ø No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide Hospital 24 hours a 🛩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai within 24 ho To the Fun completely f 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the MA Khin HOSPITALIST 12hin 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OHMMAR KHIN BK 8027028 AUGUST 29,2004 PRIME DOC

DHMH 17 Rev 1/2001

State Registrar OHMMAR

400

7th STRECT, FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHIN

31. Date filed (Month, Day, Year) SEP 0 8 2004

FMH

32. Regitrar's Signature

			1 - For State Registrar	State of M	aryland	•	tificate of		ivie	, ,	iene _{9. No.} 2 (	004	28303
	Physici	an	1. Decedent's Name (First, Middle, Las						2	. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		JAY BOSTIAN FRE  4a. Facility Name (If not institution, give				4h. City. Town, o	r Location of Dea	th	SEPT.		004 nty of Dea	6:00A M
	L.XdI,III	EI	1827 TRENLEIGH					re Count				Balti	
	Funeral		5. Social Security Number 6. S			st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	S. 8	Date of Birth (Month, Day, eb. 25	Year)	9. Bir	thplace (State or Foreign ountry)
	Director		246~28~4253 X	X   //		Yrs.			_  -	eb. 25	,1927		TH CAROLINA
	nyland how		10a. State 10b. County	_	10c. City,	Town or Lo							10d. Inside City Limits
	he Ma 8e-f s	Directo	MARYLAND BALTIMOR	E		BAL	TIMORE CO	DUNTY					1 □ Yes 2 X No
	a or 3		1827 Trenleigh R	d			10f. Zip Code	1234		10	0g. Citizen o USA	of What Co	ountry?
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. \	Vas Decedent of H Yes, specify Cuba		Speci	fy Yes or No-	14. R		erican Indian,
20	rs after I', or Ita	by Fu	1 ☐ Never Married 2CXMarried 3 ☐ Widowed 4 ☐ Divorced	1XXYes 2 ☐ I If Yes, Give Year or Dates:	No WW11		☐ Yes 2 <b>X</b> XNo	Specify:	ILO MI	can, etc.)	Spec	llack, Whit cify: W	hite
3-003c	72 hou neture lical E		15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	ent's Usual Occup	ation	rkina	1	16b. Kind of	Business	/Industry
717	itled within 72 hours after death with the Maryland Hygiene. Ither then "neturel", or Itams 23a or 28e-f show Inter the Medical Examera must be indiffed at	Completed	Elementary/Secondary (0-12) 9 yrs.	College (1-4or 5	5+)	life. L	achinist	d) mg most or we	nnuy		A.A.I	. Cor	poration
/land	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Integration of Health and Mantal Hygiens Hourstont: if Item 27 is marked other than "neturel; or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Exercact must be inclined at once.	Be	17. Father's Name (First, Middle, Last) Gibson A. Freeze					18. Mother's Na		First, Middle, M Bostia		ame)	
ary	2 shoul and Me is mark eumati	To	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street					m, State,	Zip Code)
e,	1 and 2 Health a lem 27 is		Marie E. Freeze	(Wife)	1200 -		Trenleig	gh Rd. B	-				
	ages 1 nt of H t: If ite / or ot		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐		Cel	metery, cren	sition (Name of natory or other place Cemeter)	_(e) ј у 9~7~:	Dat 200	(1)	oc. Location altimo		Town, State
altimor	permit. Pages Department of h Importent: If ite any injury or of		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Liger		1	22	. Name and Addre	ss of Facility			31011110	,	1101
Ď	Depa Impo any ii		1 6. J. La	esaln		L	assahn Fu 401 Bela	∪neral H ir Bd. B	ome alt	e :imore	Md 2	21236	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death.	Do not ente	er the mode of dyin	ng, such as cardia	corr	espiratory arre	st,		Approximate Interval Between Onset and Death
-	/Medical		Immediate Cause (Final disease or condition resulting in death)	a. Colo N Due to (or as									10 yers
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	e death he atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)					Month	Day Year
, 5	that the	y Phy	9 ☐ Unknown  Part II. Other significant conditions c		ut not result	ting in the un	derlying cause give	en in Part I.	7	23e. Did toba	acco use co	ntribute to	the cause of death?
acords,	en sigr	ed by	Pulnonning Ent	2010						1 ☐ Yes	2 🗆 No	3 🗆 Pr	obably 4 Unknown
מני	a taw re nas be e 2 sho	Completed				-				24a. Was an autopsy		prior to a	itopsy findings available completion of cause of
vital r	n: The ficate or, pag	e Cor	OF Was against stand to modical		<u> </u>					perform 1 ☐ Yes 2	266	death? 1 🗌 Yes	215/170
5	ysicia is certi directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatient	3□ DOA Othe	26. Place of De er: 4 ☐ Nursing I				ther (Spe	cify)
5	ding Physician: The taw h. After this certificate has funeral director, page 2 s		27. Manner of Veath	28a. Date of Inju (Month, Day	ry Year) 2	28b. Time of Injury	28c. Injun Work	y at k?		d. Describe hov			
202	Attend death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At hom	ne, farm, stre		Yes 2 □ No	28f	. Location (Stre	eet and Nun	nber or Ru	ıral Route Number.
5	tel or / rs after et Dire ed in b	Certification:	4 Homicide determined	building, et	c. (Specify)					City or Town,	State)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be exwining 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	edicai	29a. Certifier Certifying Ph (Check only one)	ysicien: To the best niner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occi	e, and	due to the cau at the time, dat	use(s) and r te and place	manner as e, and due	stated. to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier				29c. License			29	d. Date sign	ned (Montl	h, Dey, Year)
	,	,	I will	>				38409				3104	
	1		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type, F	Print) 井 415 1	merle	, (	nd, 21	093		
	Sta		31. Date filed (Month, Day, Year)	32. Regis	r's Signatu	re K	breeke	1 0 3 1 1 1			-		
	Registr		SEP 0 8	5 ZUU4 P	AND.	70 1	7						

DHMH 17 Rev 1/2001

			1 - State of Maryla		artment of Health and M rtificate of Death	lental Hygier		11.
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last)  Gi LBER+	Fisch	BACH.	2. Date of Death Month Septembe		death M
	Examir Funeral	ner		S. last birthday)	4b. City. Town, or Location of Death  ALT MORE  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	Ac. County of Death  N/A  9. Birthplace (State or Country)	Foreign
P	Director		Usual Residence of Decedent	Yrs.		Oct.13,1	922 Maryland 10d. Inside City	Limits
the Mary	28e-f sho	rector	PA York 0	Glen Ro	OCK	100.0	1 ☐ Yes	
IIIU KIKIJ-0000 be filed within 72 hours atter death with the Maryland	Department of Health and Mental Hygiene. Importent: If item 27 le markad other than "naturel", or Items 23a or 28e-f show with jijury or other traumatic event, the Machael Examinat rust be notified at once.	Funeral Director	7640 Simpson Road  11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13.	17327 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Un	ited States  14. Race - American Indian, Black, White, etc.	
2 hours att	naturel', or	þ	1 Never Married 2 Married 1 X es 2 No If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 ☑ No Specify:	16b.	Specify: White Kind of Business/Industry	
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<b>5, Ma</b> 1 and 2 st	Health and am 27 le r ther traur		19a. Informant's Name/Relationship (Type, Print)  Trish Iea / Daughter  20a. Method of Disposition 20b.	7640	ng Address (Street and Number or Rura  Simpson Rd., Gle position (Name of	n Rock,P		
mit. Pages 1	rtment of rtent: If its njury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer adowr i	idge Sep.	5,2004El	kridge,Maryla	
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To		M	29b. Signature and title of certifier  **Marko**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier**  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier*  **The signature and title of certifier		29c. License number  0 1444 4 2	29d. D	eate signed (Month, Day, Year)  9/3/4	
	M		29b. Signature and title of certifier	m 23a) (Type,	Printy NCReene Steet	-BALtimo,	Re MD 21201	
	Sta Registr		31. Date filed (Month, Day, Year)  SFP 0 8 2004	lature doe	de la			

CIARENCE FONTZ Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 4:13P_M Clarence Fontz 18, AUGUST 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 13, 1941 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) unk **Funeral** Months 1MM 2□F Director Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f show 1X Yes 2 □ No MD Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 USA 16 S. Patterson Avenue deeth v unk
12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No U
If Yes, Give
year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. hours after unk 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk permit. Pages 1 and 2 should be filed within 72 P. Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "natt any injury or other treumatic event, I're Madical once. 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 X Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Si nal re of Euneral Service Licensee Ronal J S . Wade 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a ATHEROSCIERATIC CARDIOMSCULAR /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and does detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à INFARCTS 1 Yes 2 No 3 Probably 4 Noknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Xes 2 No 1X Yes 2 🗆 No I or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2 1 Inpatient 2X ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel o within 24 hours aft To the Funerel DI completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

31. Date filed (Month, Day, Year)

ANA

29b. Signature and title of certified

Mary

SEP 0 8 2004

32 Registrar's Signature

and manner stated

, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO

Registrar

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 19,2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 31, 2004 9:05A M Rowena Thompson Gurdin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Carriage Hill Nursing Home Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🕅 F Months Director 336-26-2398 Jan. 1, 1917 Indiana Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event. Its Modical Eracilian: stat be ricilified at 1 ☐ Yes 2X No Directo Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 7404 Ridgewood Avenue United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Oecedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet permit. Pages 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r eny injury or other traumatic event, Ira M.A. gones. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housekeeper Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Thompson Ameda Milarn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope Douglas/Daughter 7404 Ridgewood Avenue; Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 09/03/2004 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atrial Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Hypertension Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Por Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. the detached à Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe The law requires 2√ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate has page 2 1 ☐ Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: K Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 X Natural 5 Pending 1 Tes 2 No 24 hours after death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 40051280 9-1-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive; Suite; 201; Rockville, MD 20850 Truong Bao, MD 31. Date filed (Month, Day, Year) SEP 0 8 2004 Seem & spart Registrar

DHMH 17 Rev 1/2001

ORIGINAL

04-05649 MARSHALL GILES, JR Amend item #28e per MF C835 9/8/04 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 31 2004 2004 **Physician** 1:40 P Marshall Giles, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 3218 ELMORA AVE 4b. City, Town, or Location of Death BALTIMORE CITY 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1**∑**M 2□ F Hours Min. Yrs. Director 219-17-8580 16 12-5-87 Md. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e 3166 Elmora Ave. 21213 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Specify: Black 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 grade Laborer McDonald's other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marshall G. Giles, Sr. Antoinette Ricks 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or other traconce. Marshall G. Giles, Sr. 4519 Shamrock Ave., Baltimore, Md. Father 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9-4-04 Mt. Zion Cem. Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, ,Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): nding physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 3/X/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
Yes 2□ No 24a. Was an autopsy performed? certificate Yes 2 No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  KOther (Specify) SCENE Hospital: P 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pending OY 1 🗌 Yes investigation 2 Accident Director:

Division of Vital Records.

death within 24 hours a To the Funeral I the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LARON 31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only

29b. Signature and title

6 Could not be determined

MD

House

ice of Injury - At h. xie, farm, street, factory, office ilding, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause 🗊 and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and interner stated.

29c. License number

OCME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

SEPTEMBER 1, 2004

3205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 8:29 A M Luther Washington Goad, September 5 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 112 B Philadelphia Road Joppa Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country)
Apr. 15, 1936 Virginia Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑** M 2 ☐ F 68 Director 230-38-0917 Usual Residence of Decedent buid be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County d other than "natural", or itams 23a or 28a-f show event, the Medical Example must be notified at 1 ☐ Yes 2X No Funeral Director Harford Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 B Philadelphia Road 21085 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be iment of Health and Menta tant: If Item 27 is marked Winston Willey Goad Dolly Elizabeth Warden traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 B Philadelphia Road, Joppa, MD 21085 Nancy F. Goad - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 St Burial 2 Cremation 3 Nemoval from State ° 4 □ Donatiø 5 Other (Specify) vice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature 1317 Cokesbury Rd., Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each type. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOM SMONTH **Physician** /Medical **Examiner** Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 DNo 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate ! 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 No after death. 1 Tyes 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours 8 To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ess of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31, Date filed (Month, Day, Year) State Registrar SEP 0 8 2004

DHMH 17 Rev 1/2001

			State of	of Maryland / De					
			For State Registrar		ertificate of	Death	Reg. N	0001	28309
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	Funeral Director		5. Social Security Number 6. Sex 110 M 2 G	7. Age (In yrs. last birthda 77 Yrs.	Months Days	If Under 24 Hrs.   a	Date of Birth (Month, Day, Year VGUST 6)	1927 MA	place (State or Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or					10d. Inside City Limits
	the May	ector	10e. Street and Number	DAG	IMORE 10f. Zip Code		100 (	Citizen of What Cou	1 MYes 2 □ No
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920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or flems 23a or 28e-f show other treumatic event, it is Madical Examinational be multiplied at	by Funeral Director	1 Never Married 2 Married 1 Yes	cedent Ever in U.S. orces? 2 No ive 7/12/46	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Specifican, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
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altimore,	Pa ant		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	GARRISON	V FOREST 1				, MARYLAND VERME HOME
Ba	permit. Departr Importa any inj		Vauge Gre	enl L	1905 YI	OKK KOAD	BACTI	noce, Mi	21212
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		ē	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):					6 days
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68	ertificat ting phy se as th		IF FEMALE:	deam of process					
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	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significant conditions contributing to d	death but not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco	o use contribute to the	he cause of death? pably 4 Unknown
Il Records,	sicien: The law re certificate has be irector, page 2 sho	Completed					24a. Was an autopsy performed?	prior to co death?	ppsy findings available impletion of cause of
Vital	ysicien: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	Inpatient 2 ER/Outpat	ient 30 DOA Ott	26. Place of Death (C		6 ☐Other (Specif	541
n of	ng Ph fter th meral			of Injury 28b. Time	of 28c. Inju	ry at 280	d. Describe how inj		у/
Division	Attendi death. ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be	e of Injury - At home, farm,		Yes 2 No 28f	. Location (Street	and Number or Rura	al Route Number,
ā	ital or / irs after rel Dire led in b		4   Homicide Dusic	fing, etc. (Specify)			City or Town, Sta	,	
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medicel Examiner: On the land man	e best of my knowledge, de basis of examination and/or nner stated.	ath occurred at the ti investigation, in my	ime, date and place, and opinion, death occurred	d due to the cause( at the time, date a	(s) and manner as s nd place, and due to	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Month,	
	la la		30. Name and address of person who completed cau	PHYSICIAN ise of death (Item 23a) (Typ		38946 - E8		9,01,20	<u> </u>
	15		GAUTAM GULATI 501	SAINT PAUL S		BALTIMORE, N	4D 21202		
	Sta Registi		31. Date filed (Month, Day, Year) 32. I	Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Harve Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner**  Birthplace (State or Foreign Country) **Funeral** Days Hours Usual Residence of Decedent 1 3M 2□ F Director the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Madical Exercitar must be notified at 1 es 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 13. Was Decedent it of Hispanic Origin? (Specify Yes or No Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Dec edent Ever in U.S. 11. Marital Status 72 hours after 2 **2** No 1 Never Married 2 Married 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ray injury or other traumetic event, Ita M. 4 once. RcD dary (0-12) College (1-4or 5+) 17. Father's (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Wife 19b. Mailing Address (Street and Number or Rural Route Num Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) farction Physician Myocardial /Medical Due to (or as a consequence of): Examiner Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit rgestive law requires that the death certificate be executed Or resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes 2 No nis certificate has been signed a director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à sest ho phu 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 Q No 1 ☐ Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nina J. Everett, Good Samaritan Hospital

32. Registrar's Signature

D46444

8-30-04

			1 - For Amend Item	State of Marylar 21 per DVR,09	nd / Department of <b>/08/04/hb</b>	of Health and I	-	
			Decedent's Name (First, Middle, Las		Continuate	Or Beatif	Reg.	No.) G. Time of Death
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	Examir	ner		)	4b. City, 10	wn, or Location of Deatl	n \3	4c. County of Death
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	ath v	a	3500 Old C	t. Rd	~   ~	208		SA
	ar de	nu	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or l	Y	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑	No Specify:		Specify: White
8	ural'	d b	3 Widowed 4 □ Divorced	Year or Dates:				Specify: WRITCE
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ha Madical Examinar must be recified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual C (Give kind of work of	Occupation done during most of wor retired)	king 16b	. Kind of Business/Industry
2	vithir han	d m	Elementary/Secondary (0-12)	College (1-4or 5+)				
121	filed with Hygiene, other than		12	0	Salespe			Retail
n	be fital H	Be	17. Father's Name (First, Middle, Last)	Cohom			ne (First, Middle, Maid	
yla	should be nd Mental marked c	ပို	Joseph Isadore	Cohen			e Wiesenf	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at		19a. Informant's Name/Relationship (7 Charles Hoge/Sor		19b. Mailing Address (S 4734 Wainwr	treet and Number or Ru ight Circle	ral Route Number, Cit.  Owings Mi	ty or Town, State, Zip Code)
Baltimore,	f Her f Her ttem othe		20a. Method of Disposition		Place of Disposition (Name cometery, crematory or othe	of spinors	Date 20c	. Location - City or Town, State
9	Pages nent of I ant: If Its ary or o		1 Burial 2 Cremation 3 \( \) 1 Solution 5 Other (Specify	Hemoval from State	a la la la la la la la la la la la la la	place)	1 0	11>
量	그 는 문 등		21. Signature of Funeral Service Licen	· cole	22 Name and A	erisional 51	13104 13	altracre, MD
Ba	permit. Depart Import any inj		Ronald S. Wad	DEL DVK			1, 655 W.	Baltimore Street e, MD 21201
100			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the dear	th. Do not enter the mode o	f dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
· Japan	Physician		Immediate Cause (Final disease or condition	1/1/2	7	1)1		Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consec	quence of):	voea	7	
18	Examiner			•				
\$		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of):			
	hetr	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events					
	al-tra	xa	resulting in death) Last	C. Due to (or as a conseq	quence of):			
58760,	ficate be executed physician and s the burial-transit							
387	phy:	dical		0.				
_	death certific e attending p id for use as	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy			
Вох	atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al death 3 Ectopic pregr			23d. Date of delivery  Month Day Year
o.	0 0 0	Physician/Me	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of d 9☐ Unknown	death 5 Other (specif	у)		
٥.	The law requires that the te has been signed by the page 2 should be detache	Ph	Part II. Other significant conditions co	antributing to dooth but not re-			20. 5:44-4	
ŝ	res t igne be d	b	raitii. Other significant conditions of	minuting to death but not res	salang in the andenying caus	e given in Part I.		o use contribute to the cause of death?
Record	w require been si should b	Completed					1 Tes	2 No 3 Probably 4 □Unknown
ec	e law has b	pie					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>		On					performed	death?
Vital	stcian: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Dea	th (Check only one)	A × (/ ,
>	V Si	OB	examiner? 1  Yes No	Hospital: 1   Inpatient 2	ER/Outpatient 3 DOA	Other	ome 5 Residence	6 NOther (Specify)
of		n:T	27. Manner of Death	28a. Date of Injury		Injury at Work?	28d. Describe how in	
ion	te Ati	atio	1 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		
Division	or Attending after death. Diractor: After in by the fune	ific	3 ☐ Suicide 6 ☐ Could not be	288. Place of injury - At no	ome, farm, street, factory, of	fice	28f. Location (Street	and Number or Rural Route Number.
Ö	in Sign	Certification:	4  Homicide	building, etc. (Specif	(y)		City or Town, St.	ate)
	lospital hours uneral		29a. Certifier Certifying Phy	/sician: To the best of my kno	owledge, death occurred at ti	he time, date and place.	and due to the cause	(s) and manner as stated
	12 T S	edicai	(Check only & Medical Exam one)	iner: On the basis of examina and manner stated.	tion and/or investigation, in	my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. Li	cense number	29d. [	Date signed (Month, Day, Year)
1	->-0		1 how	Sch	1	(FG7-	h	1 22 2010
, pe			20 Name and	ompleted cause of days in the	220) (Turs - Deleti	113/2	Hay	UN 21 2007
			30. Name and address of person who c	Completed cause of death (Item		X 12. +	10. m	Mr. 1. 1
	Cha	to	31. Date filed (Month, Day, Year)	32. Registrar's Signa	now Stre	pi reco	man/	1/2 1 m 1 5/12/2
	Sta Registr		SEP 0 8 2004	id at us A	made			

State of Maryland / Department of Health and Mental Hygiene

_				Otate of two	ar yraina 7 i	Certificate	e of Death	R	eg. No. 2	nı.	20212
	1		1. Decedent's Name (First, Middle, Las	st)				2. Dete of Deel	Dev	Year	3. Time of Death
Į,	Physici /Medio		Stanley	J.	He1	.m		Septemb	er 2, 2	2004	12:40 am
	Examir		4a Fecility Neme (If not institution, give	e street end number)			4b. City, Town, or	Location of Deeth	4c. County		
			Westminster	Nursing H	ome		Westm	inster		arro1	1
	Funeral		5. Sociel Security Number 6. S	ex 7. Ag	e (In yrs. lest bi	irthdey) If Under Months	1 Year If Under 24 Hrs	s. 8. Date of Birth			ece (State or Foreign
	Director		213-30-9608	<b>™</b> 2□ F	69	Yrs.	Days Hours Will	Nov. 12	, 1934	Mary	
- Sec	D		Usuel Residence of Decedent								
	how #		10a. Stete 10b. County		10c. City, Tow	vn or Location				10	d. Inside City Limits
	a Ma	ᅙ	MD Baltimo	ore		Randal	1stown				1 ☐ Yes 2X No
	き 28 ま 28	Director	10e. Street end Number			10f. Zip	Code	1	0g. Citizen of V	Vhat Countr	у?
	within 72 hours aftar death with the Maryland ana. than "naturel", or items 23a or 28e-f show its Medical Exercities must be notified at	aic	9215 Allenswoo	od Road			21133		USA		
	daa daa	Funerai	11. Meritel Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Deced	tent of Hispenic Origin? ( cify Cuben, Mexican, Pue	Specify Yes or No-		e - America k, White, et	
0	aftar or its		1 ☐ Never Married 2 【X Married	1 XYes 2 ☐ I If Yes, Give	40		2 XNo Specify:	10 1 110211, 0101,	Specify	,	
8	E	þ	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dates:		10 163	ELANO Opeany.		Specify	Whi	te
5	n 72 hours "naturel", edical Exa	Completed	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16e	Decedent's Usua	al Occupetion	orkina	16b. Kind of Bu	usiness/Indu	ıstry
7	this a se	ğ	Elementery/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT us	rk done during most of wo se retired)		Baltimo	re Co	unty
2	gian gian	5	12			Captain					artment
ā	tal Hy d oth	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Na	ame (First, Middle, I	Maiden Suman	10)	
Maryland 21215-0020	uld the Want	2	Stanley Helm	n			Anna No	OZ			
an	should and Man marke urmatic	1	19a. Informant's Name/Relationship (	Type, Print)	191	b. Mailing Address	(Street and Number or F	Rurel Route Number	, City or Town,	State, Zip C	Code)
Σ	permit. Pagas 1 and 2 should be filad within Department of Health and Mantal Hygiana. Important: if item 27 is marked other than 'any Injury or other traumatic event, the Mana Dags.		Mrs. Odette J. He	ım Wife	9	215 A11e	nswood Road.	Randall	stown.	MD 2	1133
Itimore,	to Ha		20a. Method of Disposition		20b. Place of cemete	of Disposition (Nan ery, crematory or o	ne of ther place)	Date	20c. Location -	City or Tow	n, State
Ĕ	Pagas nant of int: if its iry or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	(/)			orial Gard.	9/7/0/	Finkeh		MED
Ħ	nit.		21. Signature of Funeral Service Licen	isee	//		d Address of Fecility				
	E SE E SE		1 1 S	(1)		711			Reiste		
$\equiv$			32a Borth Enter the disease or com	Oliopunge that paused	the death Do	Eline I	Funeral Home	Reist	erstown		21136 Approximate
-			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	10.	not enter the mod	e or dying, soon as cardic	ac or respiratory on	551,	t	Interval Between Onset end Death
	Physician /Medical		Immediate Ceuse (Final		4-1	- P1		_ )			/ ) .
	Examiner		disease or condition resulting in death)	· mel	nslule	e ldl	on Conc	er			gr
		7		•	Due to (or as a	consequence of):				į	•
	bed sit	Examiner		b						1	
	rificata be axecuted ng physician and as tha burial-transit	xar	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or es e	consequence of):					
9	be a ician buria	aiE	cause. Enter Underlying Ceuse (Disease or injury	c							
68760,	cata phys	edicai	that initieted events resulting in death) Lest		Due to (or as e	consequence of):					
	E 0 6			d						1	
Вох	daath cert a attandin ad for usa	ian									
	0 00 0	Physician/	Part II. Other aignificant conditions of	ontributing to death be	ut not resulting	in the underlying ca	ause given in Part I.	23b. Did to	becco uae co	ntribute to t	the cause of death?
P.0.	d by	F						1 🗆 Y	s 2 No	3 Proba	ably 4 Unknown
	5 5 0	þ									
Š	raquira been sig should t	e d						24a. Was a perfor		avail	e autopsy findings lable prior to
Records,	aw 2 s t	pie									pletion of cause eath?
Œ	Ø - D	Completed						1UY	2 X No	10	Yes 2□ No
Vital	sician: The cartificata iractor, pa	Be C	25. Was case referred to medical				26. Place of De	eath (Check only on	<b>(a)</b>		
>	Physician: this cartific iral diractor,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3 DO	Other: 4 Nursing	Home 5 Reside	nce 6 □Oth	er (Specify)	
o	Phy aral		27. Menner of Death	28a. Date of tnju (Month, De		Time of 2	8c. tnjury at Work?	28d. Describe ho			
Division	Attending P ir daath. ector: Aftar t by tha funare	읉	1 Naturet 5 ☐ Pending investigation		/ rear/	Injury M	1 ☐ Yes 2 ☐ No				
<u> S</u>	Attendil ar daath. ector: A by tha fu	Ę	3 Suicide 6 Could not be determined	286. Place of inj	ury - At home, f	erm, street, factory	r, office	28f. Location (St		er or Rural	Route Number,
台	9 # ¥ =	Certification:	4 Homicide	building, etc	c. (Specity)			City or Town	i, Stete)		
	To the mospital or within 24 hours after To the Funerel Dirticomplataly filled in						at the time, date and plac				
	Fur lataly	edical	(Check only 2 Medical Exam one)	niner: On the besis of and manner sta		nd/or investigation,	in my opinion, death occ	curred at the time, d	ate and place,	and due to t	he cause(s)
	within To the	N N	29b. Signature and title of certifier	) 4	,	290	: License number	2	9d. Date signe	d (Month, D	ay, Year)
	->-0		I for let	hellet	- 4	-	775443		9/2/0	4	
	181		30. Name and address of person who	completed cause of d	eath (Itom 22a)	(Type Print)	12010				
	かり		To km w M	Completed Gause of 6	(HOIII 238)	SUPN	de Roan	Mest	n m (7	2 1	1 1) 2/1/17
		18	31. Dete filed (Month, Day, Year)	326 Registre	er's Signature	203100	IC VIORE	100000		3/	1 DENS/
d.	Sta Registi	1000	SEP 0 8 200	4 Comme	, K	boutes					

			For State	State of Maryland				lental Hyg	iene	
			Stata     Registrar  1. Decedent's Name (First, Middle, Las	t)	Cei	rtificate of L	Jeath	2. Date of Dea	eg. No. U	3. Time of Death
и	Physici		Norman R. Heinks					Month	Day Yea	ır
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Берсешь	4c. County of De	
			300 Cantata Cour			Reister			Balti	
В	Funeral Director		5. Social Security Number 6. Se 1	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) March 1	, Year) 9. E	Birthplace (State or Foreign Country)  Illinois
	D		Usual Residence of Decedent		<u> </u>			riar cii i	, 1721	
	faryla show	ō	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No
	r 28a-	rect	MD Baltin  10e. Street and Number	lore	Reis	terstown 10f. Zip Code		1	0g. Citizen of What	
	th with	<b>Funeral Director</b>	300 Cantata Cour	t Apt. 221		2	1136		USA	
	er dea	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
920	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: WWII		1⊡Yes 2∏XNo	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland neturel', or Hems 23a or 28a-f show deal Examinar must be multical at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	(Give	dent's Usual Occupa kind of work done d	furing most of work	ina	16b. Kind of Busines	ss/Industry
121	within one	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)		E1 + -	1
d 2	al Hygie I other vent, II	Be Co	12 17. Father's Name (First, Middle, Last)		ᆫᆫ	ectrician	18. Mother's Nam	e (First, Middle, I	Electr Maiden Sumame)	Icai
ylan	2 should be and Mental is marked ore	To B	John Heinks				Clara H	einks		
Maryland	12 shound N and N is ma		19a. Informant's Name/Relationship (7	ype, Print)					, City or Town, State	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other treatmetic event, the Medical Examinating Items Intelliged at any injury or other treatmetic event, the Medical Examinating Items Intelliged at ances.		Dorothy V. Heinks 20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of			eisterstow 20c. Location - City	n MD 21136 or Town, State
altimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		natory`or other place Cremation		/04	Hampstead	4 MTD
Balti	permit. Departn Importe eny inju		21. Signature of Funeral Service Licen:		1	. Name and Addres			Reisters	
	40 E 8 9		23a. Part 1. Enter the disease, or comp	lication that arread the death		line Fune			erstown, N	
	Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	- 110	or the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):	my Mu	DA LANGE	ma		I year
г	Examiner	_	Sequentially list conditions,	b						
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (uř as a cunsequ	oliče Utj.					
o,	execu an and rial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical		d					<del></del>	
9	eath certific attending p for use as t	/Mec	IF FEMALE:	23c. If yes, outcome of pregnar	nev				204 D ( 4	
. Box	death e atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
P.0	that the de led by the a detached t	hys	9 🗆 Unknown	9Ll Unknown				1		
Vital Records,	w requires that been signed be should be det	by	Part II. Dther significant conditions co	ontributing to death but not resu	lting in the ur	nderlying cause give	n in Part I.	23e. Did tob	- V	to the cause of death?  Probably 4 □Unknown
eco	B 8 C1	Completed						24a. Was ar	24b. Were	autopsy findings available completion of cause of
E E								perform	ned? death? No 1 ☐ Ye	0/
	Physicien: The ribis certificate har al director, page	o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	26. Place of Death	V		
ס ר		-	27. Manner of Death 1 Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury Work	-		nce 6 ⊡Other (Sp w injury occurred	өспу)
siol	ttendir death. stor: Af	catlo	2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	′es 2□No			
Division of	after deatl	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre )	et, factory, office		28t. Location (Str City or Town		Rura I Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier Certifying Phy	vsician: To the best of my know	vledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and manner	as stated.
	the H hin 24 the F nplete	Medical	one)	iner: On the basis of examinati and manner stated.	on and/or inv					
)	T wit	-	29b. Signatu/e and title of certifier	- Glick 1	1 *	29c. License	005/10	7 / )	od. Date signed (Mor	70011
	141		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type,	Print)	a I	. 1	1 11	mone MD 2125
	Sta	te	31. Date filed (Month, Day, Year)	32 Aegistrar's Signati	24/	OL W. E	DEIVERE	RE MV	E., DAH	MORE MD 21215
×.	Registr	- 1	\$ER/0 8 201	14 them s	X As	and a				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 28, 2004 Year Physician Pearl V. Harrison 11:00 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis German Hill Baltimore Baltimore 8. Date of Birth (Month Day, Y If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Hours Days 1 □ M 2 🗙 F 216-36-0946 66 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumetic event, the Medical Examiner must be notified at MD Baltimore Completed by Funeral Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) caregiver home health care 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Dean ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Alexander/sister 1018 Statford Street Clarksville, TN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Signature of Funeral Sprace Licensee Ronal S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed ENSTOX Division of Vital Records, P.O. Box 68760, attending physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 D No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☑ No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 🗌 Yes 2 🗌 No 2 Accident 3 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 0 8 2004 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

				•	Certificate of Death	R	eg. No.	0001
	Dhysisi		1. Decedent's Name (First, Middle,	Last)		2. Date of Dee	th 200	Year 3 Time of Death
	Physici /Medic		ELIZABETH /	to LLAND		August	25 20	64 4:55 PM
	Examin		4a Fecility Name (If not institution, g			r Location of Deeth	4c. County o	f Death
1			UNIVERSITY ST			0.		
	Funeral Director		212-56-2987	Sex 7. Age (In yrs. les	st birthday) Yrs.  If Under 1 Year If Under 24 Hr Months Days Hours Mir		Year) 1916	9. Birthplace (Stete or Foreign Country)
	end **	-	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	Maryler f show	6	MD		HIMORE			1 ☑ Yes 2 ☐ No
	r 28a-f	5	10e. Street end Number	Dri	10f. Zip Code	1	0g. Citizen of W	hat Country?
	th with	Funeral Director	601 5 CHADLE	s Street	21230		11.0	9
	death	nera	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-		- American Indian,
Maryland 21215-0036	within 72 hours after death with the Marylend ane. than "natural", or items 23e or 28e-f show he Medical Exercites must be notified at	5	1 Never Merried 2 Married 3 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	rto Hican, etc.)	Specify:	, White, etc. Black
2-0	72 ho	ह	15. Decedent's (Specify only highest of	Education	16a. Decedent's Usual Occupetion	odkina	16b. Kind of Bus	iness/Industry
21	ig ig	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of we life. DO NOT use retired)	orking .		V
2		3	UNK	-41	UNK	ana a (Fire a dainelle d	UN	K
anc	8 to 2 to 3	Be	17. Father's Neme (First, Middle, Le	S()	18. Mother's Na	ame (First, Middle, I	vialden Surname	)
Ž	d 2 should be f th end Mentel I 7 Is merked of traumatic eve	ို	19a. Informant's Name/Relationship	(Type Print)	19b. Mailing Address (Street and Number or F	Rural Routa Number	City or Town S	trato Zin Codol
Ma	0 = 1 =		MD. Commen Agin		10 N. CALVERT ST. BALLE			
	ges 1 end 2 t of Health if Item 27 I		20a. Method of Disposition	20b. Plac	ce of Disposition (Neme of netery, cremetory or other place)			City or Town, State
Baltimore,	Z = Ba		1 Marial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify) M7	CARMEL	9-2-04	BAlto.	MD
Bal	permit. Pa Departmen Important any Injury		21. Signature of Funeral Service Lic	valier	22. Name and Address of Fecility Michael Ziglier Fu P.O. Box 67338 E	in Suc., P.	4. D.2013	5
			23e. Pert1. Enter the diseese, or so shock, or heart failure. List on	mpilcations that caused the death. ly one cause on each line.	Do not enter the mode of dying, such es cardia			Approximate Interval Between
	Physician							Onset and Death
4	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac	e arythemias			
		ē.	•	1	s e consequence of):			
	uted ansit	Examiner		U	elevatic heart also se consequence of):	eas-e		i
ó	death certificate be executed e attending physician end ed for use es the buriel-trensit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or e.	s e consequence oi).			
68760,	icate be e: physiclan s the burie	edical	Cause (Disease or injury that initieted events	c Due to (or as	s a consequence of):		-	
68	9 G G	Med	resulting in death) Last	·				i
Вох	leath certifice attending ph of for use es t	and and		d				1
E	e dea the at ned fo	Sici	-		ng in the underlying cause given in Part I.	23b. Did to	bacco use cont	ribute to the cause of death?
P.O.	requires thet the death cer een signed by the attendin hould be detached for use	£	H-pontons in	Respiratory feilure	Diaheles mellihis	1 □ Y	s 2 No :	3 ☐ Probably 4 ₺ Unknown
ds,	ires ti signe d be d	d l				240 Wos s	- autonou	24b. Were autopsy findings
Ö		ete	ceaehrelascule	accident		24a. Wes a perform		available prior to completion of cause
Records,	e lav has ge 2	Completed by Physician/				177000		of death?
<u>a</u>	ician: The certificate rector, per		25. Was case referred to medical		OS Dinns of De	eath (Check only on		1 ☐ Yes 2 ☑ No
5	Physician: this certific	∞	examiner?	Hospital: 1 Inpatient 2 ☐ ER	Out			(Specify)
Division of Vital		Certification: To	27. Manner of Death		Bb. Time of Injury et Work?	28d. Describe ho		
Ö	ath. r: Aft	읉	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	on	M 1 Yes 2 No			
Vis	r Atte	<b>≗</b>	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be d 28e. Plece of Injury - At home building, etc. (Specify)	s, farm, street, factory, office	28f. Location (St. City or Town	reet and Number , State)	or Rural Route Number,
	rs aft	Ö						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 ☐ Certifying F 2 ☐ Medicai Exp	Physician: To the best of my knowle aminer: On the basis of examinetion end manner steted.	edge, deeth occurred at the time, date and place n end/or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and man ate and place, an	ner es stated. d due to the ceuse(s)
	To the Conj		29b. Signature end title of certifier		29c. License number	29		(Month, Day, Year)
					030490	4	8/201	04
	\		30. Neme end eddress of person wh	completed ceuse of deeth (Item 23	3e) (Type, Print)			
	\		KDESAIMO 71CH	naidon choice lone	Balhmore MD DIXX	8		
	Sta Registra	.e	31. Dete filed (Month, Dey, Year) SEP 0 8	2004 Signature 2004	Balhmore MD & LLZ			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** 2004 FRANK HAWKINS , JR. 7:30 PM 9UGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 325 N. GRANTLEY STREET BALTIMORR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 10XM 2□F MD 220.24.0221 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic avant, the Medical Examinations is the northled at NIA MD BALTIMORE 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 325 N. GRANTLEY STREET 21229 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 5€Yes 2 ☐ No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: PLACK 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction CONTRACTOR 10th grade 17. Father's Name (Birst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H FRANK HAWKINS, SP MAMIE. PATTERSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is in any injury or othar traum once. ANNE HAWKINS 325 N. GRANTLEY STREET BALTO. MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 BBurial 2 ☐ Cremation 3 ☐ Removal from State 09.08.04 BALTIMORE, MD BALTO, NAT'L *4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility PENE FUNERAL SERVICES 21. Signature of Funer Pervice 23a. Part1. Enter the disease, or complications that aused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTO. NATIONAL PIKE BALTO MD 212201 Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician 1006 Widel YEAR disease or condition resulting in death) /Medical Due to (or as / conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed the burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð The law requires phrosderessis FAILURE e 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed NSUFFICIEN 1 Yes 2 No Physician: 25. Was case referred to examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 \( \tag{Nursing Home} 2 1 🗌 Yes 5 Residence 6 □Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t Hospital or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TTENDING 16200 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN Chace LA CHIRAN 8 2004 Regist State Registrar

			1 _ Stete	Maryland /	-		lealth and Me		ath oth	
			Registrer  1. Decedent's Name (First, Middle, Last)		Cer	tificate of		Reg 2. Date of Death	J. No.?	3. Time of Death
	Physicia		William Charles Ha	ac Cr				Month	31 2	Year 2230 M
	/Medic Examin		4a. Facility Name (If not institution, give street and numb			4b. City, Town, or	r Location of Death	=lug	4c. County	
	LAGIIIII		Saint Agnes HEALTH			BALTI	more	-		N/A
	Funeral			Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Mar. 6,	'ear)	Birthplace (State or Foreign Country)
	Director		213-36-105/	65	Yrs.			Mar. 6,	1939	Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Many I sh	tor	MD Baltimore			Lansdow	ne			1 □ Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of W	Vhat Country?
	ath wi	rai	2423 Saratoga Avenue				21227		United	States
	er de:	Funeral	11. Marital Status 12. Was Deced	es?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)		e - American Indian, k, White, etc.
36	irs aft	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	□No Unknown es:	. 1	☐ Yes 2X No	Specify:		Specify:	White
9-0	2 hou	ted	15. Decedent's Education	1	6a. Deced	lent's Usual Occup	ation	16	b. Kind of Bu	siness/Industry
216	thin 7 le.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5+)	life. L	OO NOT use retired	•	9		
121	led w tygier her th		12		T	ruck Driv		(Fine 14:44) 14		sters
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hyghens. Department of Health and Maralla Hyghens. Insturet, or Itama 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	Be	17. Father's Name (First, Middle, Last)  Henry Haas				18. Mother's Name	Stengle		θ)
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address (Street	and Number or Rural			State Zio Code)
S	nd 2 salth ar 27 ls 27 ls r trau		Claudia Haas Wife				a Avenue,			
ē,	ts 1 and 1 Hez		20a. Method of Disposition		e of Dispos	sition (Name of	Da	te 20	c. Location	City or Town, State
<u>n</u>	Page nent c ant: If ary or	1	Magnetian 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate Crest	Gard		9-4-2	004 м	arriot	tsville, MD
alt	apartr aportr ny inji	1	21. Signification of Funeral Service Licensed	T/A) 0			ss own rose			f Lansdowne
	205 20	1	Comme Dicker	Mia	-					, MD 21227
			23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. [ h line.	Do not ente		_			Approximate Interval Between Onset and Death
- 84	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hensi	ve	Athero	scleroti	- Cardi	OUASWI	ar years
	Examiner		Du to (or	as a consequen	ice of):				Diseas	
	1	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequen	ice of).					
P.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events							
,00	ate be execu physician and the burial-tra		resulting in death) Last Due to (or	as a consequen	ce of):					
8760	ate he he	dicai	d							
( ×	certific nding p use as t	/Me	IF FEMALE: 23c. If yes, outco	me of pregnancy	,				204 0-1	
Box		Physician/Me	in the past 12 months?	h 2 Fetal death	ath 3 🗌	Ectopic pregnancy Other (specify)			Mon	of delivery oth Day Year
.00	that the d ed by the detached	nysi	1  Yes 2  No 9 Unknown 9 Unknown							
ان م	w requires that the death been signed by the atte should be detached for	by Pi	Part II. Other significant conditions contributing to dea	h but not resultin	ng in the un	iderlying cause give	en in Part I.	23e. Did tobac	co use contri	bute to the cause of death?
つ gb	requires een sign nould be	edt	hypercholesterolem	1A				1 ☐ Yes	2 <del>  N</del> o	3 Probably 4 Unknown
		Completed	Obesity					24a. Was an autopsy	24b. W	Vere autopsy findings available rior to completion of cause of
7 =	The law cate has b page 2 sh	Соп	1					performe	d? de	eath? □Yes 2□No
Vital	ician: The lar certificate has rector, page 2	Be	25. Was case referred to medical examiner?				26. Place of Death	Check only one)		
0 0	Physician: this certificanal director.	. To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inc.  27. Manner of Death 28a. Date of		Outpatient		4   Nursing Home	e 5 ☐ Residence		
o do	ding th. After fune	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Day Year)	Injury	28c. Injun Work	Yes 2 □ No	d. Describe flow	пцину оссите	90
Visi	I or Attanding Phys after death. Diractor: After this in by the funeral di	ifica	a Could not be	Injury - At home	, farm, stre	eet, factory, office				or or Rural Route Number,
	s afte	Certification:	4 Homicide determined building	, etc. (Specify)				City or Town, S	itate)	
	Hospital or 24 hours afte Funeral Dir tely filled in	_	29a. Certifier 1 Certifying Physician: To the base (Check only 2 Medical Exeminer: On the base)	est of my knowled	dge, death	occurred at the tim	ne, date and place, an	d due to the caus	e(s) and mar	nner as stated.
	the the the	Medical	one) and manne	stated.						
	o t with	~	29b. Signature and title of certifier			29c. License				(Month, Day, Year)
	h		20 Namehold address	of dooth /lt co	)a) /T	900	773	/	, regus 1	3. 12.04
	9		30. Name and address of person who completed cause			itus Ar	onne Be	altmor	e, d	131, 2004 Uaryliae C
	Sta	te		istrar's SignAture		N. S.				
	Registr	ar	JEI 0 0 2004		1					

			. For	State of Mar	yland / Depa			•	•	
			1 = State Registrar		Cei	rtificate of E	Death	Re	g. No.2 () () L	28318
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Ruth Madeline Ho					Septemb	er 5, 200	
	Examir	er	4a. Facility Name (If not institution, give : Paradise Assisted			4b. City, Town, or Catonsv			4c. County of De Baltimo	
	Funeral		5. Social Security Number 6. Sec	7. Age (	'In yrs. last birthday)	_ If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.8	
÷	Director		213-20-9191	]м 2[XF] 10	00 Yrs.	Months Days	Hours Min.	July 4,	1904 Ma	rthplece (State or Foreign Country) ryland
	yland		10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	B Mar	ctor	Maryland Baltimor	е	Catonsvi	.11e				1 ☐ Yes 2 🔀 No
	ith th	Director	10e. Street and Number			10f. Zip Code		1	g. Citizen of What C	ŕ
	s 23s		6348 Frederick Ro			21228	0::0::0::0		United St	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f ehow entry injury or other traumatic event, the Medical Examinar must be mailfied at once.	Funeral	11. Marital Status 1  Never Married 2 Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	į.	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
93	urel',	d by	3 [™] Widowed 4 Divorced	Year or Dates:					Specify: W	hite
<u>ה</u>	n 72 t	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ing	6b. Kind of Busines	s/Industry
7	withii iene. than	ошо	Elementary/Secondary (0-12) 8th Grade	College (1-4or 5+)		ceptionis			Metal Worl	c Company
d	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		c company
<u>la</u>	uld be Menta rrked ric ev	To B	Frank Geisbert				Edna Ma	e McLane		
Maryland 21215-0036	2 sho and P ts me		19a. Informant's Name/Relationship (Ty	•		ng Address (Street ar				
<u>ک</u>	and lealth m 27		Beverly Mae Cammar		The second second					
Baltimore,	int of H		20a. Method of Disposition  1XD Burial 2 Cremation 3 P	emoval from State	cemetery, crer	sition (Name of natory or other place)  National	Com		Oc. Location - City o	
	iit. Partmer artmer ortant injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligens						altimore,	
Ba	Depa Impo eny ii		Dem /	1 Samo		Name and Address TZKE Fune				
23	n		23a. Pert1. Enter the disease, on compli shock, or heart failure. List only or	cations that caused th	e death. Do not ent	30 Edmond er the mode of dying.	such as cardiac	or respiratory arres	isville, i	Approximate
	Pnysician		Immediate Cause (Final disease or condition	Cause on each line.	ourend	alzhu	innike	Den	DIA	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a c	consequence of):	( Jugen	- 10000 2	prod	muc.	far.
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7	ed sit	ine	Sequentially list conditions, in the sequential sequence cause. Enter Underlying Cause (Disease of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequence of injury the sequ	Due to (or as a c	consaguence of:					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
760,	0 0 0	caiE								
	leath certificat attending phy I for use as the									
ŏ	th cer tendir r use	an/N	230. Was decedent program	3c. If yes, outcome of a		Ectopic pregnancy			23d. Date of de	livery
O. B	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at tim 9☐Unknown		Other (specify)			Month	Day Year
<u>.</u>	that the de led by the a detached	P _y	Part II. Other significant conditions con	stributing to death but r	not resulting in the ur	aderiving cause given	in Part I	23a Did toba	cco use contribute t	o the cause of death?
ds,	uires Iha signed Id be det	d by		thousand to appear part	Tot Tosuling III the un	idenying cause give	inir aiti.			robably 4 DUnknown
Records,	w require been si should b	iete						24a. Was an		utancy findens available
Re	The lav	Completed						autopsy performe	prior to death?	utopsy findings available completion of cause of
		0	25. Was case referred to medical				26. Place of Death	1 Yes 2 (Check only one)		s 2□ No
o to	Physician: r this certifica ral director, p	To B	examiner? 1 □ Yes 2 ☑ No H	ospital: 1  Inpatient	2 ER/Outpatien	Other		me 5 ☐ Residen	-	city) asestelling
	afte and		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury a Work?	at	28d. Describe how		,
Sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				s 2 □No			
		Certification;	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre 'Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in 1		29a. Certifier 1 Certifying Phys	sician: To the best of n	ny knowledge, death	occurred at the time	, date and place, a	and due to the cau	se(s) and manner a	s stated.
	he Ho n 24 t he Fu bietely	edical	(Check only 2 Medical Examination)	ner: On the basis of ex and manner stated	camination and/or inv	estigation, in my opir	nion, death occurr	ed at the time, date	e and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	- /		29c. License	number	290	I. Date signed (Mon	th, Day, Year)
			alyander luge	e le		1000 8	780	9	18/04-	
	B		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print)	94	0 300		
	Sta	to.	ALESANDRO 31. Date filed (Month Day, Year)	32 Pagistrar's	Signable	togdens	k Nol - h	sallinen	19021	728
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 200	4 Miles	11					

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Year **Physician** Vivian R. Hanssen 3,0004 3:00pm sentember /Medical 4a Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Center Kosedale Franklin Square Hospital Age (In yrs. last birthday) If Under 1 Year | Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛛 F Hours Director 215-03-4840 Maryland 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 1 Yes 2 □ No Funeral Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? e filed within 72 hours after death with tall Hygiene. other than "naturel", or items 23s or 2 U.S.A. 14. Race - American Indian, 21206 4012 Pinewood Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☼ No Specify: δ 3 XWidowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi end Mental I Ruth Workinger Douglas A. Lauf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wermit. Peges 1 end 2 Depertment of Health en. Important: if Item 27 is meny Injury or other 909 Shelburne Road - Bel Air, Maryland 21015 Charles A. Hanssen, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 09/08/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 23a. Part. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical · Acute CVA Examiner Due to (or as a consequence of): Physician/Medical Examine ettending physician and for use es the bunal-trensit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Fibrillation, hypertension Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No nours efter death. death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital within 24 hours e To the Funeral Completely filled 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ma inchis September 3,2004

State

Registrar

Viviar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 8 2004

LONG

32 Pogistrar's Signature

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			1 - State Registrar		Ce	rtificate of Death		Reg. N	1000	00000
	0,		1. Decedent's Name (First, Middle, Las	st)				of Death	C 0 0 4	3. Time of Death
	Physici		Emily	М.,		Hunt	Augu	st 30,	2004 Year	3:20 P M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of			c. County of Death	3.20 1
	LAGITITI	-	Holy Cross Hospi			Silver Spring			Montgomer	77
	Funeral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year If Under 2		of Birth		
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	nylan how		10a. State 10b. County	10c. City	, Town or Lo	ocation				Od. Inside City Limits
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	r 28	Director	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ent, the Medicul Examinar must be molified at	ai D	907 Nova Avenue			20743			USA	
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S		Was Decedent of Hispanic Orig	gin? (Specify Yes	or No-	14. Race - Ameri	
ယ	after or Ita	교	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2√2√No		If Yes, specify Cuban, Mexican,	, Puerto Rican, e	tc.)	Black, White,	
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<u>a</u>	Ald b Aents rked ric a	To B	Pasquale Sansal	one		Mai	ry Cupid	lo		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Importent: If Itam 27 ia marked othar than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avent, the Medical Exantistic formatic at political at once.		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street and Number	r or Rural Route	Number, City	or Town, State, Zip	Code)
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Baltimore,	s 1 a f Hear Itam othe		20a. Method of Disposition	20b. Pt	ace of Dispo	sition (Name of matory or other place)	Date	20c.	Location - City or To	own, State
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P.O. Box 6	ng Phyaician: The law requires that the death cer ufter this certificate has been signed by the attendir uneral director, page 2 should be detached for use	Medical Certification: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1	23c. If yes, outcome of pregnar  1	ting in the understand the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	26. Place of the state and vestigation, in my opinion, death	23e  24a  1 □  of Death (Check sing Home 5 □  28d. Des  28f. Loca City  d place, and due h occurred at the	Was an autopsy performed? Yes Z⊠N only one)  Residence cribe how injuition (Street a or Town, State time, date an 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, date and 29d. Discontinuous control of the cause(strime, da	Month  o use contribute to the contribute to the contribute to the prior to condeath?  1	Day Year  ne cause of death?  ably 4 Unknown  psy findings available inpletion of cause of 2 No  I Route Number,  ated. the cause(s)

			For State	State of N	Maryland / Depa	artment of I rtificate of		nd Mental Hy		1 0000.
			Registrer  1. Decedent's Name (First, Middle, La	st)	06.	Tillicate Of	Dealii	2. Date of De	Reg. No.2	3. Time of Déath
1	Physici		Joseph	P.		Ha11	Sr.	Month August	31, 2004	9:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give		r)	4b. City, Town,			4c. County o	
×			8504 Heatherwick	Drive		Brandy	vine		Prince	George's
n	Funeral		5. Social Security Number 6. S	Sex 7. A M_XM 2□F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi ( <i>Month, D</i> ) 03/18	rth ay, Year)	Birthplace (State or Foreign Country)
de	Director		217-32-3309	nizim Zur	67 Yrs.			03/18	/1937	Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	tor	Maryland Prince	George's	Brandyw	ine				1 ☐ Yes X2X <b>∑</b> No
	or 288	Director	10e. Street and Number	9		10f. Zip Code			10g. Citizen of WI	hat Country?
	within 72 hours after death with the Maryland ene. then "naturel", or liems 23c or 28a-f ehow he Medical Ever in etr. staff ke ricilihad at		8504 Heatherwi	ck Drive		20	0613		USA	
	Items	Funeral	11. Marital Status	12. Was Deceder Armed Forces	5?	Was Decedent of If Yes, specify Cub	dispanic Originan, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race Black	- American Indian, White, etc.
36	s afte	by Fu	1 Never Married XX Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates	XNo	1 ☐ Yes 2XX No			Specify:	White
Ş	ture!	ed k	15. Decedent's E	i		dent's Usual Occu	pation		16b. Kind of Bus	
215	nin 72	Completed	(Specify only highest grant   Elementary/Secondary (0-12)	ade completed) College (1-4o	(Give	kind of work done DO NOT use retire	during most of	of working		
212	filed within Hygiene. other then ent, the M	mo.	12	Oblige (1-40		rpenter			Constru	ction
pu	be filed within 72 hours after death with the Marylar ital Hyglene.  ad other then "naturel; or Items 23s or 28a-f ehow od other then "naturel; or Items 23s or 28a-f ehow event, the Medical Ever in etc. as it he rediffed at	Be	17. Father's Name (First, Middle, Last					s Name (First, Middle		)
yla	should be filed within and Mental Hygiene. s marked other then umatic event, the M	^o L	William Jenning					nna Tippe		
Maryland 21215-0036	2 2 2		19a. Informant's Name/Relationship (		10			or Rural Route Numb		
رة آ	ges 1 and 2 f of Health If item 27 or other tr		Cartha Hall / Wi	Ге	20b. Place of Dispo	sition (Name of		one Drand		ryland 20613 Sity or Town, State
nor	0 0		1 ☐ Burial 2√12Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		comptant pro-	matory or other pla	<i>сө)</i>   09	/02/2004		r, Maryland
Baltimore,			21. Signature meral Service Lie					P. Kalas	-	
ñ	21. Signature of heral School Lice Heral 22. Na						Hill R	Road Oxon	runerai Hill.Marv	land 20745
			23a. Parti Enter the disease, or com should, or heart failure. List only	plications that caus						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LUN						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					
	LAGITIFIE	<u></u>	Sequentially list conditions,	b. Due to for a	is a consequence of:					
	ted nsit	nine	Sequentially list conditions, any leading control to cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of					
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical		d						
9	rtificat ng phy as th	Medi	IS ESTABLE.							
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth		DEctopic pregnanc	y		23d. Date	,
0.	at the dea by the al tached fo	Physician/Me	1 Yes 2 No	4□ Pregnant 9□ Unknown	at time of death 5	Other (specify)			Monti	h Day Year
0	that the		Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause or	ven in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
Vital Records,	uires signi ld be	d by	-			, , ,		,		□ Probably 4 □Unknown
COL	w require been significant	ompleted					-	24a. Was	an 24h We	ere autopsy findings available
Re	The lar ate has page 2	omp						auto	pripripripripripripripripripripripriprip	or to completion of cause of ath?
ta		O	25. Was case referred to medical				26. Place of	1 ☐ Yes f Death (Check only		Yes 2 No
of V	dis di	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpa	tient 2 EP/Outpatier	nt 3 DOA Ct	ner: 4 ☐ Nursi	ing Home 5 Resi	idence 6 □Other	(Specify)
U O			27. Manner of Death  1 Natural 5 □ Pending	28a. Date of In (Month, D	jury 28b. Time o lay Year) Injury	Wo	rk?		how injury occurred	d
Sio	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		aium. Athama fat		Yes 2 □ No	_	/G4	2 /2 / 1
Division	of or Attend after death Director: / d in by the f	Certification;	4  Homicide determined	building,	njury - At home, farm, str etc. <i>(Specify)</i>	еві, тасіогу, опісе		City or To	wn, State)	or Rural Route Number,
	spite ours nere		29a. Certifier 1 Certifying Pl	nysicien: To the bes	st of my knowledge, deat	h occurred at the ti	me, date and p	place, and due to the	cause(s) and manr	ner as stated.
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	(Check only 2 Medicel Exer	miner: On the basis and manner:	of examination and/or in	vestigation, in my	pinion, death	occurred at the time,	date and place, an	d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licen:			29d. Date signed (	(Month, Day, Year)
•	1/		Jisams	pus		D4	8128		SEP OI,	2004
	()		30. Name and address of person who	,			- n	Δ Δ Δ		2.2
	Sta	to	SISOM OSIA M- 31. Date filed (Month, Day, Year)	32 Poni	trada Cianatura		>1C 70	0 OXON	HILL MY	) 40 +4)
1	Registr		SFP 0 8	2004	due &	mode				

DHMH 17 Rev 1/2001

			1 - For Stete Registrer	State of M	arylan	id / Depa		t of H	ealth a		lental Hy		200	4	283	22
	D		1. Decedent's Name (First, Middle,	Last)							2. Date of De	eath Day	Ye	26	3. Time of	Death
	Physici /Medic		Joshua D. Jacks	son							August	24		04	1:27	$P^{M}$
	Examin		4a. Facility Name (If not institution,		)		4b. City,	Town, or	Location o	of Death			County of E			
			The Memorial Ho			to a filiabeta 1	Cur If Under	nber.	land If Under:	24 Hrs	0.00	I	Allega			
L	Funeral Director		187-62-0435	6. Sex 7. A	22	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi	ⁿⁿ 1 ⁷ 98:	2 P€		ylvan:	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							100	I. Inside Cit	y Limits
	8a-1 sh	ctor		Butler	Har	mony									1 <b>≰</b> Yes	2 🗌 No
	with the	Dire	10e. Street and Number				10f. Zip					-	zen of What		/?	
	s 23g	era	160 Slinner Lane	12. Was Decedent	Ever in II	C 12	160		opania Oria	ain? (Car			ed Sta		Indian	
980	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or Itams 23e or 28e-f show event, if a Marical Examilian or until by muffield at	by Funeral Director	11. Marital Status  1 ▼ Never Married 2  Marrie 3  Widowed 4  Divorced	Armed Forces	?		was Deced fYes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	Black, V		С.	
5-0	72 hc	etec	15. Decedent' (Specify only highest	s Education grade completed)		16a. Deced	dent's Usua kind of wor	l Occupa	ation Turina most	t of worki	na	16b. Ki	nd of Busine	ss/Indu	stry	
21215-0036	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Ride	DO NOT us	e retired,	)			Carı	nival			
Maryland	should be filed withir nd Mental Hygiene. marked other than imatic evant, II e M	To Be C	17. Father's Name (First, Middle, L Glenn Jackson	ast)							(First, Middle Inknown		Sumame)			
Mary	nd 2 should th and Men 27 Is marks traumatic		19a. Informant's Name/Relationsh Herman Aeschbach		l		-				I Route Numb				ode)	1
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marka any injury or othar traumatic 000.0.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation			Place of Dispo	sition (Nam	ne of ther place	9)	C	ate	20c. Lo	cation - City	or Town		
altin	permit. Pag Department Important: I any injury o		`4 Donation 5 Other (Sp 21. Signature of Funeral Service L		Hu	and the second second					1/2004 eral_Ho			enns	syrvar	11a
8	97 = 9		23a. Part1. Enter the disease, or of	complications that cause	d the deat	4	01 S.	Cne	ster	Stre	et Bal	timo	ce, Ma	-	and 2'	
	Pnysician		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each I	ine.									Ir	iterval Betw Inset and D	reen
	/Medical Examiner			Due to (or as	a conseq	uence of):										
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as	a conseq	uence of):										
8760,	ate be executed hysician and the burial-transit	Ical Exa	resulting in death) Last	C. Due to (or as	a conseq	uence of);										
687	ficate physis the	edic		d										+-		
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	I death 3	Ectopic pre Other <i>(spe</i>					2	3d. Date of Month	delivery Da	ay Yı	ear
ecords, P.	w requires that the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of the back of th	by	Part II. Other significant condition	ns contributing to death t	out not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	^	se contribut		cause of de	
$\mathbf{\alpha}$		Completed											24b. Were prior death	to comp	y findings a letion of ca ☐ No	vailable use of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Harrisot						of Death	(Check only	one)				
of \	phys this al dii	2	1  Yes 2 No	Hospital:		ER/Outpatien		- 1	4 🗀 1901	-	ne 5□Resi			pecify)		
	ng ftel	lon	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	Bc. Injury Work	?		28d. Describe					
Division	Attanding r death. actor: After by the fune	Certification	2€ Accident Investigation 3 Suicide 6 Could not	ot be One Place of In	iury - At ho	12:29P			′es 2⊡N		Subject 28f. Location (					ar.
Div	after Dira Jin by	ertii	4  Homicide determine	building, e	c. (Specif	y).	Joi, ladiory,	, 011100			City or To	wn, State)				<i>51</i> ,
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only 2 Medicel E	Physicien: To the best eminer: On the basis	of my kno of examina	wledge, death	occurred a	at the tim	e, date and inion, deat	d place, a	and due to the	umbs	rland	as state	d.	
	To tha within 2 To tha Complet	Med	29b. Signature and title of certifier	and manner si	ated.			License					signed (M			
)			30. Name and address of person w	the stimpleted cause of	heath (line	0 23a) /T-m-	Print)		O.C.	M.E.		Aug	ıst 25	, 20	004	
		(	I ARen (1)	UE, M)	aean (Iteli			n St	reet	Ra1	timore	Mar	ryl and	211	201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture						, 1301	- <u>7</u>		UT_	
	Registr	ar	SEP 0 8 200	4 Benen	~ /	D A	pork	2								

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

year

Day

Year

1√2 Yes 2 □ No

Maryland

health

1:54 AMM

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Lillian Johnson August 29, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 219-10-3155 78 Director Mar 22, 1926 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Medical Exprension rivest by scullified at MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 903 W. University Parkway #201 21210 USA death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked othar than "natural", or Itar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) licensed practical nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stefan Mateja Frances Zawadska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Shannon/son 903 W. University Parkway #201 Baltimore, MD 21210 if of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Luneral Sectice Licen 22. Name and Address of Facility State Anatomy Bo Baltimore, MD Wades 101 B21281 655 W. Baltimore Street mans 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prysician lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be executed Cause (Cleanes of Iriju that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. tha 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ director, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed ohnson, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes Atter this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Physician a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID BEKELMAN

DHMH 17 Rev 1/200

State

Registrar

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32. Bigistrar's Signature

0 8 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. AMEND ITEM #20a&b PER FH C835 9/08@Actifycate of Death Rea. Nd: s Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death = 50 PM Day Month **Physician** n19 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ture Mewood If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. lest birthday) 5. Social Security Number Sex Birthplece (State or Foreign Country) Funeral Months Days 1 □ M 2 🕽 F 237-38-046 Yrs. north Director Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 KaYes 2 □ No Funeral Director 1/2moi 12 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 2700 21218 Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 📉 No Specify: Black If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) end Mental Hygiene. Sekee Item 27 is merked other other traumetic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 end 2 should be George OWL Jones order or Rurel Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Nu. 19a. Informant's Name/Relationship (Type, Print) trank of Health 124 en altimore. 20b. Place of Disposition (National Competence of Disposition (National Competence of Disposition (National Competence of Disposition (National Competence of Disposition (National Competence of Disposition (National Comp 20a. Method of Disposition Date Department of important: If it any injury or or 1 № Burial 2 Cremation 3 Removat from State 4 ☐ Donation 5 ☐ Other (Specify) et 112004 21. Signature of Funeral Se ce License 198 170 8% Melus Zul 23a. Part1. Enter the disease, or complications that a wied the death. Do not enter the mode of dying, such as cardiac or respir tory arrest shock, or heart failure. List only one cause on each line. **Physician** tmmediate Ceuse (Final disease or condition resulting in death) /Medical cardiovaswic a. Atherescle ratic never Examiner Due to (or as a consequence of): Examiner he The law requires that the death certificete be executed nding physician end use es the bunel-transit Unkrew Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as e consequence of): attending p Mellitus ed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? n signed by the 3 Probabty 4 Unknown 1 ☐ Yes 2 ☐ No Brisst þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director: After this certificate hes I completely filled in by the funeral director, page 2: 1LL Yes 24 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of tnjury 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 04 MD D0059056

Registrar

State

6821

Reisterston Rd

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30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

3 Registrar's Signature

5.

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DALJEET

31. Date filed (Month, Day, Year)

Robert King Jr 04-05679 RPD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)		To the within To the compl	Me	29b. Signature and title of certifier	,		29c. Lice	nse number		29d. Date	e signed (Month, L	Jay, Year)
Panete Downhaud.mi) O.C.M.E. September 2, 2004				Yamet Douth	au.mo			.M.E.		Sep	tember 2	, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pamela E. Swithall, MD  111 Penn Street, Baltimore, Maryland 21201						m 23a) (Type,	111 Pen	n Street,	Baltimo	re, I	Maryland	21201
State  State  SEP 0.8.2004  32. Registrar's Signature				31. Date filed (Month, Day, Year)		ature	/					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harry H. Keller, Jr. 5, 2004 3:30 p M September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll 8. Date of Birth (Month, Day, Year May 25, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Days Hours Min 216-10-5460 Director 87 Maryland Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10h County 10a State 10d. Inside City Limits ?7 is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Madical Examinar must be notilited at Lutherville 1 ☐ Yes 2 ☑ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21.093 11233 Greenspring Avenue USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after de I Hygiene. other than "natural", or Items Black, White, etc. 1 Never Married 2 Married 1√2Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ WII 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Furniture Elementary/Secondary (0-12) College (1-4or 5+) Handyman Sales 1 and 2 should be filed wi Health and Mental Hygien Iem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Garrish Harry H. Keller, Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other traignes. Carol L. Hyneckeal, daughter 524 Goldenrod Terrace, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 09/10/2004 Finksburg, MD 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00723 934 South Main St, Hampstead, MD 21074 23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to fur Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a gonspouence off-Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE esr 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. the a detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate 2000 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 1 ☐ Yes 2 ☐ No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 1X Natural 5 Pending death. 1 Tyes 2 Accident investigation Director: 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 \ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signatore and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 488 idilleton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

		,	For State Registrar		State	of Mary		partmei e <i>rtifica</i>				Mental Hyg	iene	n.	293	20
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	Director		076-01-1524 Usual Residence of Deceden	1 □ M 2 【 <b>XF</b>	91 Yrs.	Months Days	Hours Min. Oct	ober 7, 1	912 Ne	hplace (State or Foreign untry) W York
	ırylanı show	_	10a. State 10b. Co	•	10c. City, Town or L					10d. fnside City Limits
	he Ma 28a-1	ecto	MD. Ba.	ltimore	Dunda.			40-	0111-	1 ☐ Yes 2 📉 No
	3a or	DI	7600 Berkshi	re Road		10f. Zip Code 2122	24	log.	Citizen of What Co USA	uritry ?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it iam 27 is merked other than "natural", or itams 23a or 28a-1 show or other traumatic event, the Mydical Expression must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 ▼ Widowed 4 □ Divo	12. Was Dece Armed Fo 1  Yes If Yes Giv	.2 <b>X</b> No /e		Hispanic Origin? (Specify an, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, White	
5-0	72 ho	eted		edent's Education ighest grade completed)	(Give	dent's Usual Dccu kind of work done	during most of working	16b.	. Kind of Business/	Industry
2121	2 should be filed within and Mental Hygiene. Is marked other than "aumatic event, the Mac	Completed	Elementary/Secondary (0- 0 years	12) College (1	-4or 5+)	DO NOT use retire usewife	d)		Own Home	
nd	ba file stal Hy id oth	Be	17. Father's Name (First, Mic				18. Mother's Name (First		en Sumame)	
Maryland	should nd Men marka umatic	2	Nicholas Wert		19h Maifi	ng Address /Street	Maria Ha	<u>-</u>	v or Town State 2	Tip Code)
M	and 2 s ealth an m 27 is i		Mary Ann Kowa				Road, Jarre			1084
Baltimore,	Pages 1 a nent of Hea int: If itam iry or otha		20a. Method of Disposition	ion 3 Removal from	20b. Place of Disp	osition (Name of matory or other pla	ce) Septemb	ær ^{20c.}	Location - City or	
Baltii	permit. Pag Department Important: It any in ury o		21. Signature of Funeral Ser		00 2	2, Name and Addre	Funeral Home ers Point Ro	of Dur	ndalk.P.A	
	Physician /Medical Examiner	ner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a So Due to (	aused the death. Do not en ach line.  of as a consequence of):  or as a consequence of):	Colit	8,	piratory arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edical Examiner	Cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of):					
P.O. Box	ires that the death certificate signed by the attending phys d be detached for use as the	Completed by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live b	ant at time of death 5[	☐Ectopic pregnanc ☐ Other ( <i>specify</i> ) _	у		23d. Date of deli Month	very Day Year
	uires that signed b Id be deta	d by Pi	Part II. Other significant cor	ditions contributing to de	eath but not resulting in the u	nderlying cause gr	ven in Part I.		1/	the cause of death?
of Vital Records,	ne law requir has been si ge 2 should i	mplete	Renal !	Jaile			2	24a. Was an autopsy	prior to c	topsy findings available completion of cause of
Ta Ta		e Co	25. Was case referred to me	dical	-		26. Place of Death (Che	performed?	No 1 ☐ Yes	2□ No
Į V	d s	o B	examiner?	Hospital: V	npatient 2 ER/Outpatie	nt 3 DOA Ott			6 ∏Other (Spec	iifv)
ion of	nding Ph ith. :: After thi e funeral	atlon: T	27. Manner of Death  1 X Natural 5 Per 2 Accident	28a. Date		Wo		Describe how in		,,
Division	or Attanding after death.  Diractor: After d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined 28e. Place building	of Injury - At home, farm, st ng, etc. (Specify)	reet, factory, office	28f. L	ocation (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Cert (Check only 2 Med	ical Examiner: On the ba	best of my knowledge, deal asis of examination and/or in her stated.	h occurred at the ti vestigation, in my o	me, date and place, and d opinion, death occurred at	ue to the cause the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 7 To the comple	Ž	29b. Signature and title of ce	0		29c. Licen:			Date signed (Month	
)			,	dalt-So,		D.	26250		Sept. 2	12004
1	0		30. Name and address of per		e of death (Item 23a) (Type,	Print) TH CHAI	zbzso	SALTIA	IORE, M	021204.
	Sta	ite	31. Date filed (Month, Day, Y	(əar) 32	egistrar's Signature		•			

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Chang Soon Kim August 30, 2004 10:30 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 948 Wampler Lane Westminster Carroll 8. Date of Birth (Month, Day, Year) Nov. 25, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Days Hours 72 Director 216-17-8279 1931 South Korea Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 948 Wampler Lane 21158 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Madical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Asian Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keun Ja Le Daughter 3019 Old Westminster Pike Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Sept 1, 2004 Marriottsville, MD Crest Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road entens 10 ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 1/24/15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Cther (specify) 4 Pregnant at time of death 1 Yes 2 No the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 🗆 Yes 2 No 1□ Yes 2 100 Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Majural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: A 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 \( \text{Homicide} \) To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) buth juta street 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 8 2004 Registrar

Kaja Knutrud Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-05569 State of Maryland / Department of Health and Mental Hygiene **RPD** Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kaja I. Knutrud August 28, 2004 1130A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 4201 Linthicum Road Dayton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 XF 79 Director 310-36-0520 April 10, 1925 Norway Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Howard Ellicott City Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 U.S.A. 8081 Old Montgomery Road or items 23a r death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after stal Hygiene." natural, or ite 1 Never Married 2 Married 2 No 1 🗆 Yes Specify: Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Nursing Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Mental Important; if item 27 is marked any injury or other traumatic evone. Margit Brudal Thorleif Knutrud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8081 Old Montgomery Road Ellicott City, Maryland 21043 Daughter Ms. Eileen Smith 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place; 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Services, Inc. 08/31/2004 Sykesville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Reter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DROWNING Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Completed by OBSTRUCTI VE PULMONARY DISETSE 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? filled in by the funeral director, page 2 certificate Yes 2□No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other:  $4 \square \text{ Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \cancel{X} \text{Other (Specify)} \quad \text{At Scene}$ XXYes 2 □ No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Dilatural 2 Accident Injury 5 Pending SMY SOU DROWNED -28-04 Fairo 11-20M 1 🗌 Yes death. investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 4201 CINTHIUMRD HONDING MY POND AT ASSISEDLIVING TRULITY the Hospital within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar MARGARMA

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0-

KORGU 32. Registrar's Signature O.C.M.E.

August 28, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4, SEPT 2004 8:45 ALFRED F. LONIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BAYVIEW MEDICAL CENTER BALTIMORE N/A7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Funeral 1 M 2 □ F Months Days Hours Yrs. Director 84 11/20/19 075-14-5894 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director N/AMD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 423 GUSRYAN STREET 21224 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: þ 3 Widowed 4 Divorced Year or Dates: WW II WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 GLENN L. MARTIN ELECTRICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACOB ANALONIS MARY KRIJANAUCKAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. MARY LONIS / BALTIMORE, MD. WIFE 423 GUSRYAN ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Department of F Important: If ite any injury or otl once. 1 № Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) MIDDLE RIVER, MD. HOLLY HILL MEM. 9/8/04 21. Signature of Funeral Service Lice KACZOROWSKI FacilFUNERAL HOME P.A. Robert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1201 DUNDALK AVE. BALTIMORE, MD. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myozar disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Tyes of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Division 5 Pending 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) D-28097 Paraed attarasio MO Merntt Bevd. Suttet 14 Balt Md. 21222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1576 RODALD ATTAWASIO 31. Date filed (Month, Day, Year) 32. Register's Signature State Klew & Aprile 0 8 2004 ▶ Registrar

Glenn Dwight Littlefield Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-05681 State of Maryland / Department of Health and Mental Hygiene RPD 1 - For State Registrar Certificate of Death lent's Name (First, 2. Date of Death Middle, Last) 3. Time of Death Day **Physician** si am September 1, 2004 1133 P M /Medical a. Facility Name (If not institution, see street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, **Funeral**  Birthplace (State or Foreign Sountry) **M** 2□ F Months Days Hours 1-88-897 Yrs. Director al Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show Alical Examiner must be natified at Director 1 Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 7 Is marked other than traumatic event, I've Ma Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Ears 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 18. Mental nt's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stable partment of Health ar Important: If item 27 Is any injury or other trauonce. Baltimore, 20a. Method of Disposition 20c. Location Pages 1 1 Burial 2 Cremation 3 F
1 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** Gunshot Wounds /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lner Due to (or as a consequence of) death certificate be executed physician and the burial-transit Exam Due to (or as a consequence of) Physician/Medical SB IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. JYes 2 □ No detached 9 Unknown þ signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been: 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a. Was an autopsy performed? page certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **™** Yes 2 🗆 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Prust PM 5 Pending 1 Natural death. 2 Accident investigation 1 Yes 2 No subject was shot completely filled in by the Director 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bathmore, vehicle Street 1200 block - Homewood Ave. ON To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southail, Hamela B. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day Ear) State Registrar

			1 - For State Registrar	State of	Marylan		artment o			Mental Hyg	iene	n I.	28331
	Physici /Medi		1. Decedent's Name <i>(First, Middl</i> e Agnes Marie					-		2. Date of Deat Month Sept.	Day	Year 2004	3. Time of Death
	Examir		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Tow	n, or Loca	tion of Deat	h	4c. County	of Death	
			Ridgeway Manor N					nsvi			Ba]	.timo:	
	Funeral Director		5. Social Security Number 219-16-7562 Usual Residence of Decedent	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. 9.		If Under 1 Ye Months Da		nder 24 Hrs urs Min.	8. Date of Birth (Month, Day, May 20,	^{Year)} 1912		lace (State or Foreign http) yland
re, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examinar runal be notified at ODGe.	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Howan  10e. Street and Number  5837 Timberviev  11. Marital Status  1 Never Married 2 Marrie  3 Nover Married 4 Divorced  (Specify only highests  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, L.  John Pitzinger  19a. Informant's Name/Relationsh  June Cobb - Date  20a. Method of Disposition	V Drive  12. 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Kind of Bu  Own Haiden Surnam  City or Town,	What Coun  State  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - America  - Am	tes an Indian, etc. White dustry  Code) 21075
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,8760,	The law requires that the death certificate be executed by the law requires that the death certificate be executed by the attending physician and agge 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (a	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or a consequent or	uence of):						l	
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or Vital	hys this al di	າ: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 □ In	patient 2 🗆 I	ER/Outpatient 28b. Time of	JLI COM	0.4		th Check only one ome 5 Resident 28d. Describe how	ce 6 ⊡Othe		
DIVISION	al or Attending F s after death. I Director: After d in by the funer	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	of Injury - At ho	Injury me, farm, stre		☐ Yes 2	2 🗆 No	28f. Location (Stre	et and Numbe	or or Rural	Route Number
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	ne Ho n 24 h ne Fu	edical	(Check only 2 Medical E.	xaminer: On the bas and manne	is of examinati	ion and/or inv	estigation, in m	y opinion,	death occur	red at the time, dat	e and place, a	nd due to t	he cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier  Cueha	Dayn 1	MD			9.75		290	d. Date signed Septen	(Month, D.	ay, Year) 7,2004
	2		30. Name and address of person w GEETHA RA	ho completed cause	of death (Item 436	23a) (Type, F 7 Holl	ins fe	hile	Rd,	Baltivi	none,	MD	7,2004
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 20		gistrar's Signat	иге	2	<i></i>					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WRENCE ELYN 0:00PM 2004 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death secours OSPITA Year If Under 24 Hrs. Social Security Number (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Months 316-12-5853 Usual Residence of Decedent 1 □ M 2 🗙 F Yrs. Nov.11, 1 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mor 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5319 Bos 20b. Place of Disposition (Name of cemetery, crematory or other pla Satto, Md. 21207 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) re of Funeral Service dicensee Part . Enter the disease, or complica shock or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1ECTROLYTE Squadally ast conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner eloma Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 20 No 1 🗆 Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 212 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Peath Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner burial-transit The law requires that the death certificate be executed Box 68760, attending physician for use as the buria Records, P.O. page 2 Division of Vital To the Hospital or Attending Physician: after death. in by within 24 hours a

To the Funeral E

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ျ Medical Certification:

**Funeral** 

Director

28a-f show

or Items 23a or

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injury or other traumatic evant, the Mudical Evaniner must be notified at

any

Physician

/Medical

Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

MEDICAL

STAFF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a, Certifier

FA. HAMILTON, M.D, BON SECOURS HOSPITEL, 2000 W. BALTIMORE ST. BALTIMORE MD, 21223 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as suggested.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death THOMPSON MARABLE **Physician** AUGUST 10:50 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth Month, Day, MARCH 14 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days VIRGINIA 9 Hours Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at SAUTIMORE 1 No 2 No Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23g or DECKER 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Odban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Coilege (1-4or 5+) GOVERN MENT ISTODIAL ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMPSON MARABLE ALEKANDER ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is MARABLE 1516 WIFE DECKEK 20b. Place of Disposition (Name of cemetery, crematory or other) . Method of Disposition 1. Mytchewchiller Canary 9.7.04

22. Name and Address of Facility Wivight 1 Burial 2 Cremation ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any is ROAD BATIMORE, MARILAND 2/2/2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER THE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physican and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending thours after death.

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2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 034184 mon Name and address of person who completed cause of death (Item 23a) (Type, Print) YURE RO #100 TOWSON MD 21204

DHMH 17 Rev 1/2001

State Registrar

			1 - State Registrar	of Maryland / Departi Certif	ment of Health and Micate of Death	ental Hygiene Reg. Ne	2001. 20227
		sician edical	1. Decedent's Name (First, Middle, Last) WILL E	MAR MI	LLS	2. Date of Death Month Da	3. Time of Death
	Exa	miner	4a. Facility Name (If not institution, give street and HOSPH 5. Social Security Number 6. Sex	AL	o. City, Town or Location of Death  BATIMOR  Under 1 Year   If Under 24 Hrs.	E	: County of Death
	Fune		5. Social Security Number 6. Sex 1 M 2 1 F	3 1	onths Days Hours Min.	8. Date of Birth Month, Day, Year, APKIL 27,	9. Birthplace (State or Foreign 1912 NORTH CAROUNA
	death with the Maryland ms 23a or 28a-f show	ctor	10a. State 10b. County	10c. City, Town or Location	) ORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with th	ral Director	40 E. 28th STRE		0f. Zip Code 21218	10g. Ci	tizen of What Country?
	036 ours after des rai', or Itams	by Funeral	1 Never Married 2 Married 1 Yes,	s 2 VNo	Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto F Yes 2 <b>1</b> No Specify:	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: DLACK
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, Important: If itam 27 15 marked or other than "natural", or Itams 23a or 28a-1 show any injury or putper trainmatic awant the Mental Hygiene.	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  Colleg	ad) (Give kind	s Usual Occupation of work done during most of working NOT use retired)  Domest IC	g 16b. K	Cind of Business/Industry  PRIVATE
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	ore, Mary as 1 and 2 sho of Health and itam 27 is m		FLORA HULMES DA	VGHTER 410 E	ddress (Street and Number or Rural . 28th Street	BAUTIMO	or Town, State, Zip Code) RE, MD 21218
	Baltimore, Permit. Pages 1 ar Department of Hea		20a. Meyhod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro '4 ☐ Donation 5 ☐ Other (Specify)	om State  20b. Place of Disposition cemetery, cremato.  M D NATIONA	ry or other place)	-an	ocation - City or Town, State TIMORE, MARY LAND TENE TWEERN HOME
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	tha Hospi in 24 hou tha Funar	edical	Check only 2 Medical Examiner: On the	the best of my knowledge, death occ b basis of examination and/or investig anner stated.	urred at the time, date and place, ar gation, in my opinion, death occurred	d due to the cause(s) d at the time, date and	and manner as stated. I place, and due to the cause(s)
•	To 1 To 1	Σ	29b. Signature and title of certifier	awforn, mi), FAEP	29c. License number  D \$7088		e signed (Month, Day, Year)
		4	30. Name and address of person who completed care how P627 301		# 701, Bentimer	, m) 210	202
		State istrar	SEP 0 8 2004	Registrar's Signature	actie		-

LLIA	M MULL		- State Unpend Ite	State of m 23a,pt.II	Maryland / Dep	artment o	of Health a	nd Mental Hy t <b>as</b>	giene	28338
			Decedent's Name (First, Middle					2. Date of De	eath	3. Time of Death
	Physici /Medic		William		Mull			AUG.	23, 2004	1230 P M
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J	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Y Months Da		4 Hrs. 8. Date of Bi Min. (Month, D	rth 9. Bi	rthplace (State or Foreign
무료	Director		215-86-1212	142 M 2 L F	38 Yrs.	WIOTILIS DE	ays Hours	03-20		yland
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	show	5	,							1 X Yes 2 □ No
	the Maryla 28a-f sho	ect	MD 10e, Street and Number		Baltimor	10f. Zip Coo	do		10g. Citizen of What C	ountar?
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	eath w	era	212 N. Mount  11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	2122 Was Decedent		in? (Specify Yes or N	USA 0- 14. Race - Am	erican Indian.
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93	urs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:	1⊡Yes 2🛣	No Specify:		Specify: B]	ack
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Maryland	d tal	Be	17. Father's Name (First, Middle,					's Name (First, Middle		
<u>Ş</u>	s 1 and 2 should be fi if Health and Mental H item 27 is marked ot other traumatic avar	၉	William A. M		401 14 18			la Thomps		
Na Na	12 sh hand 7 is n traun		19a. Informant's Name/Relations						per, City or Town, State,	Zip Code)
	1 and 2 Health tem 27 i		Sheila Mull 20a. Method of Disposition	(mortner)	2 I Z	THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RESERVE TO THE RE		Balto. M	1D 21223 20c. Location - City o	r Town State
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		Î,	23a. Part1. Enter the disease, shock, or heart failure. Lis	complications that cau only one cause on eac	sed the death. Do not en th ine.	er the mode of	dying, such as o	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- W	cations of D	iabetes	Mellit	us		
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ó	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or	as a consequence of):					
8760,	cate be chysicia the bur	icai		d						
39	eath certifica attending ph for use as the	Physician/Medical	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal death 3[	Ectopic pregn			23d. Date of de Month	Day Year
o.	at the de by the a tached f	ysic	1 Yes 2 No	4⊟Pregnan 9⊟Unknow		Other (specify	у)			-
P.O.	that the		Part II. Other significant conditi	ons contributing to deat	th but not resulting in the u	nderlying cause	e given in Part I.	23e. Did	tobacco use contribute t	to the cause of death?
Vital Records,	or De	ompleted by	Seizure Disorde	er				1 🗆	Yes 2 □ No 3 □ P	robably 4 Unknown
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ot <	hysicil this cer al direct	70	XXYes 2 No	Hospital: 1 ☐ Inp				sing Home 5 🗆 Res	idence 6XOther (Spe	ecify) AT SCENE
) 2	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of (Month,	Injury 28b. Time of Injury		Injury at Work?		how injury occurred	
Sio	Attendii death. ctor: A y the fu	cati	2 Accident invest	not be			1 ☐ Yes 2 ☐ N		(0)	
Division	l or Attencater death Diractor:	ertification;	4 Homicide deter	nined 286. Place of	f Injury - At home, farm, st j, etc. <i>(Specify)</i>	reet, factory, of	tice		(Street and Number or Rown, State)	turai Houte Number,
J	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	edical Ce	(Check only 2 X Medica	Examiner: On the basi	est of my knowledge, deat is of examination and/or in					
	o tha ithin 2 o tha xmple	Med	one) 29b. Signatore and title of certific	and manne	Stateu.	29c. Lie	cense number		29d. Date signed (Mon	th, Day, Year)
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		1	30/Name and address of person	who completed cause	of death (Item 23a) (Type,	Print)	7.78			
			TATRICIA A	Ironica-t	311 17	-	et, Bal	timore, Ma	ryland 2120	1
	Sta	ate	31. Date filed (Month, Day, Kear	232. Reg	gistrar Signature				1	
	Registi	rar	35	P 0 8 2004	Here &	Asses	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shadera Mc Cray 04-05713 For Ar Registrar State of Maryland / Department of Health and Mental Hygiene Amend Item 2&Unpend Item 23a&26-ppg-ame-06836ath0-5-04 tas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 04 Day Month 9 **Physician** 08:48 hadena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Sinai Hospital

5. Social Security Number 6. Sex If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Min. Hours 1 M 2 4 F 218-69-3469 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD 15 ALTO Director OWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Bon 21136 452 Items 23a death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: if tem 27 is marked other **-- any injury or other treasments. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 N No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. B lack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIA N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Robinson angy To Ho ward 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bon · mother 21136 elslerslown Kabinson Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State (6) Wood lawn Come ton • 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 701 MeGILLOGS Douglass Funeral Sarvice ar Hon BAJO.MD 23a. Part I. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Myocarditis **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) Yes ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 🗆 No 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: Certification; To 1 √Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel I To the Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 X Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Toista & Treenhers Ma O.C.M.E. September 05, 2004 30. Name and address of person who completed cause of # ath (Item 23a) (Type, Print) M.D Greenberg 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 6:47 A M 03 Calvin McGuthrie Sept. 2004 /Medical Maurice 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge 8013 Hill Rise Court Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 60 **Director** 578-60-2600 Sept.1/1944 Wash.D.C. Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumetic event, the Madical Examinary ust be notified at 1 Tyes 2 XNo Director Elkridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21075 8013 Hill Rise Court USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 72 hours after 1 Never Married 2 Married Yes 2 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: Black þ 3 Widowed 4 Divorced Year or Dates: neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fited within 7
Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 is marked other the 12 Postal Worker <u>Postal Service</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Jones William Marshall McGuthrie 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 sint of Health an: If item 27 is it Tosha Medley H. McGuthrie 8013 Hill Rise Court, Elkridge, MD. 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery Sept.7,2004 Landover, Md. 22. Name and Address of FacilityWitzke Funeral Homes, Inc. 21. Signature of Funeral Service Licer @ grown 5555 Twin Knolls Rd.Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cance 0100 disease or condition resulting in death) 3 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner executed burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 99 Physician/Medical lhe. as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes ANO 1 Yes 2 🗆 No : After this certification : After this certification : To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural Natural 5 Pending r death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 - Homicide hours after within 24 hours a r Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M Hann 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RO DENNIS HANNON OLNEY-SANDY SPRING 2001 UWRY 31. Date filed (SEP) 92 Registrar's Sig 8º2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 5:00A M Mary В. Middleton September 7 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 38 Dungarrie Road Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. (Month, Day, Year) | April 21,1917 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 20€ F 579-18-8294 87 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rithen "natural", or items 23a or 28a-f show the Modical Exposurer mant be notified at 1 ☐ Yes 2XXNo Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Dungarrie Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) other then Nurse Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be t Henry Portzen Rosie Kleutch and Is m 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If Item 27 Is any njury or other traus Carlisle A. MIddleton (Husband) 38 Dungarrie Road Catonsville, MD 21228 Saftimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 9-10-04 Baltimore, Maryland 21. Signature of Funeral Service Lipense Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Cinskorio **Physician** 4 cars /Medical Examiner loen er bred Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit and physician at s the burial-ti Due to (or as a consequence of): Physiclan/Medical as Box IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or in the past 12 months? Day Year 5 Other (specify) P.0. the 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been Ouncertia - Sonile 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page certificate 1 Yes 2 No 1 Yes 2 7 No of Vital 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 7 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending within 24 hours after death. To the Funeral Director; A investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kan undo 0004932 whenes h 405 Frederick Road Suite 162 tationwite. mo. 2124 30. Name and address of person who com, leted cause of death (Item 23a) (Type, Print) 10 SABUNDAYO ROLENDO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2004

Registrar

			1- For State of Mar		artment of Heal		tal Hygier	2001	28342
	Physici	4	1. Decedent's Name (First, Middle, Last)  Virginia Beryl Martin				Date of Death Month D 1gust 28	Day Year 2004	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	***************************************	4b. City, Town, or Loca	ation of Death		c. County of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (i	In yrs. last birthday)			Date of Birth Month, Day, Yea ay 10, 1	Anne Arı	undel place (State or Foreign intry)
	Director		411-60-4930 1□M 2  ▼F  Usual Residence of Decedent	65 Yrs.	Worlds Days Tic	Ma	ay 10, 1	939 Tei	nnessee
	anyland show	_		0c. City, Town or Lo			_		10d. Inside City Limits 1,☐ Yes 2 ☐ No
	r 28a-f	recto	Maryland Queen Anne's  10e. Street and Number	Stevensv	ille 10f. Zip Code		10g. (	Citizen of What Co	Λ
	ath with	Funeral Directo	110 Brickhouse Road		21666			SA	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28e-f show any figury or other traumatic event. The Medical Examination multiled at ance.	þ	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispan f Yes, specify Cuban, Me 1 ☐ Yes 2X☐ No Sp	nic Origin? (Specify exican, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: W	
15-0	in 72 h	ojetec	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during OO NOT use retired)	g most of working	16b.	Kind of Business/I	ndustry
212	ed with ygiene. ser than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Chef			estuarant	
land	ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) Thurman Pierce			Mother's Name (Fir aggie Mor		en Sumame)	
Maryland 21215-0036	and 2 should be filed within eath and Mental Hygiene. n 27 is marked other than " ler traumatic event, the Men	-	19a. Informant's Name/Relationship (Type, Print) Mitchell Martin/Son		g Address (Street and Nogwood Str	Number or Rural Ro	ute Number, City		ip Code)
lore,	Pages 1 a nent of He int: ff Item iry or othe	100	1 ☐ Burial 2 XCremation 3 ☐ Removal from State		natory or other place)	Date		Location - City or 1	
Baltimore,	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Fun- al Service Licert e	. 22	In Cemetery Name and Address of imple Tribu	Facility		entwood,	
	~ C = 4 0		23a. Part1. Enter the disease, or complications that caused the		imple Tribu 040 Rockvil erthe mode of dying, su			le, MD 20	Approximate
	Pnysician /Medical		resulting in death)	monia					Interval Between Onset and Death
ı	Examiner		Due to (or as a constitution to the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions o	onsequence or;					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Unsets of Injury that initiated events	onsequence of):					
8760,	icate be executed physician and s the burial-transit		resulting in death) Last  Due to (or as a c	onsequence of):			÷		
.O. Box 68	ne death certif the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√2 No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
<u>α</u>	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given in	Part I.		use contribute to	the cause of death?
ecords,	w require been si should b						•		bably 4 Unknown
$\alpha$	: The law cate has I	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2	prior to condeath?	opsy findings available ompletion of cause of
Vital	Physician: The ribis certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Hospital: 1 ★npatient	2 ER/Outpatien	Other	Place of Death (Ch		6 ∏Other (Spec	ifv)
ion of	ding Ph h. After th funeral		27. Manner of Death 1 Anatural 5 Pending (Month, Day Y) 2 Accident investigation			28d.	Describe how inj		-
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (	- At home, farm, str Specify)	eet, factory, office	28f. L	Location (Street a City or Town, Sta	and Number or Rui ite)	al Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  Cartifying Physician: To the best of repair of the basis of examinar: On the basis of examinar on the basis of examinar on the basis of examinar of the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of examinar on the basis of ex	camination and/or inv	estigation, in my opinior	n, death occurred at	t the time, date a	nd place, and due	to the cause(s)
)	S S With	N	29b. Signature and title of certifier	10	29c. License num	187	29d. D	Date signed (Month)	Day, Year)
	1		30. Name and address of person unaccompleted cause of deal	th (Item 33a) (Type,	Print) A. J.	( M.)	000	Centa	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's			1			
DH	MH 17 Rev 1/2	46 8	SEP 0 8 2004	& for	We .				
				ORIGINA	L				

Murphy, Edna

	ian	Decedent's Name (First, Middle, Las CYNTHIA	st)	MAXWELL				2. Date of D Month Aug •		2004 ^{ear}	3. Time of Death 9:35 a
/Medic Examir		4a. Facility Name (If not institution, give Univ. of Maryla	street and number) and Medic	al Syst	4b Sity,	lown or Loca	tion of Death	1	4c. 0	County of Dea	th /A
Funeral Director		266-88-6819	7. Age □ M X□ F <b>56</b>	(In yrs. last birthday	/) If Under Months		nder 24 Hrs. urs Min.	8. Date of B (Month, D	irth <b>1/3/</b> Pa <i>y, Yeer)</i> , 1946	<b>1948</b> . Bir Cc	thplace (State or Fore puntry) Maryland
sd at	ō	Usuel Residence of Decedent  10a. State 10b. County  Maryland N/A	Δ	10c. City, Town or L	_ocation	Baltimo	ore				10d. Inside City Lim
a or 28a- be notif	Director	10e. Street and Number			10f. Zip	Code	1230		10g. Citize	en of What Co	ountry?
jiene. r than "natural", or items 23a or 28a-1 show It e Medical Experiment aust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 € N If Yes, Give Year or Dates:		. Was Deced If Yes, spec	ent of Hispani ify Cuban, Me		ecify Yes or N Rican, etc.)		4. Race - Ame Black, Whit	erican Indian,
giene. er than "natur. It e Medical	Completed by	15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usua e kind of won DO NOT us	k done during		sing		of Business ederal Go	Industry overnment
nd Mental Hygie marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Leroy [	Dennis			18. N	fother's Nam	e (First, Middle Millio	e, Maiden S cent Joh		
aith and N 27 Is ma r trauma		19a. Informant's Name/Relationship (T						al Route Numb			Zip Code)
Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e one.		20a. Method of Disposition  1 1 □ Burial 2 □ Cremation 3 □ 1  1 □ Donation 5 □ Other (Specify,	Removal from State	20b. Place of Disp cemetery, cre	ematory or oti	ne of her place) nurch Cen	1	Date 09/01/04	20c. Loca	ation - City or Maryl	
Departing Imports any injuice.		21. Signature of Fune al Service Licens	To II	2	Ada	Address of F	ral Home	P.A. I Aquasco	Md20	1608	
ysician and fedical aminer transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a End S	ratory F consequence of): tage Ren consequence of):				,			Onset and Deat 24 Hou:
by the attending prached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 6 9 □ Unknown	2 ☐ Fetal death 3 [	□Ectopic pre □ Other <i>(spe</i>				23	d. Date of deli Month	very Day Year
gned be de		Part II. Other significent conditions co	ntributing to death bu	t not resulting in the u	underlying ca	use given in P	art I.		tobacco use		the cause of death
certificate has been si ector, page 2 should	e Completed	25. Was case referred to medical			1	00.5	N ( D)	1 ☐ Yes	psy prmed? 2 No	prior to death?	topsy findings availa ompletion of cause
<u>o</u> :≣	ToB		Hospital: 1 🔯 Inpatier 28a. Date of Injury (Month, Day			04	] Nursing Ho	n <i>Check on</i> li me 5 □ Resi 28d. Describe	dence 6[		ify)
무유 는	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st (Specify)	reet, factory,	office		28f. Location ( City or To	Street and f wn, State)	Number or Ru	ral Route Number,
al Direct		29a. Certifier 1 X Certifying Phy	sicien: To the best of	f my knowledge, deat	th occurred a	t the time, date	e and place,	and due to the	cause(s) ar	nd manner as	stated.
within 24 nours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exami	iner: On the basis of and manner stat	ed.	ivestigation, i	opinion,	death occurr	ed at the time,	uate and pi	ace, and due	to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2004 Year **Physician** R. Glynn Mays Jr August 26, 10:28 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month | Days | Hours | Min. | Aug 9, | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 131-22-4535 83 Alabama Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28e-f show other treumstic event, it a Maxical Expansion must be notified at 1 ☐ Yes 2√2 No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 Cliff Pine Drive 20879 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 142–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US foreign officer state of MD of Health and Mental Hy tem 27 Is man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rayford Glynn Mays Lois Irene Priest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Christopher Mays/son 7103 Cliff Pine Drive Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of H 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Importent: I any injury o ' 4 X Donation 5 ☐ Other (Specify) 21 Signature of Euneral Service Licensee
Ronald S. Wade Firector State Anatomy Board 655 W. Baltimore Street baltimore, MD 21201 23a. Plut1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) **Physician** pneumonia /Medical Due to (or as a consequence of): **Examiner** respiratory failure Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit pancreatic cancer Due to (or as a consequence of): physician Physician/Medical renal insufficiency the t as t IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9☐ Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page certificate 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certified 29c. License number tem 23a) (Type, Print) 30 Name and agress of person ntgomery Den.

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records.

Registrar's Signature

Hari

0 8 2004

31. Date filed (Month, Day, Year)

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	Examir		4a. Facility Name (If not institution, give s			4b. City, Town				4c. County o			
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	Funeral		5. Social Security Number 6. Sex	7. Age ( <i>In yr</i>	s. <i>last birthd</i> ay) () Yrs.	If Under 1 Ye Months Day		Min. (Mo	te of Birth onth, Day, Yea	ar)	Counti		רון
	Director		213-64-2399 Usual Residence of Decedent					Aug	10,	1934	Mar	yland	_
	yland		10a. State 10b. County	10c. 0	City, Town or Lo	ocation		,			10	d. Inside City Limits	s
	Mar P-f st	to	MD N/A			Balti	more					1 X Yes 2 ☐ No	С
	or 28	Director	10e. Street and Number			10f. Zip Cod	e		10g.	Citizen of Wh	nat Countr	ry?	
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	tems	Funerai		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Or Cuban, Mexica	rigin? (Specify Ye ın, Puerto Rican,	es or No- etc.)	14. Race Black	<ul> <li>America</li> <li>White, et</li> </ul>		
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			23a. Part1. Enter the disease, or compli	cations that caused the de	ath. Do not ent	er the mode of o	dying, such as	cardiac or respi	ratory arrest,			Approximate	_
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	CTO	tic (	7 CC.	~				Interval Between Onset and Death	
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	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of).								
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	eath certific attending p for use as	₩.	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of preg						23d. Date	of deliven	v	
Вох	d for a	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fe 4□Pregnant at time of		Ectopic pregna Other (specify)				Montl		Day Year	
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s, P	The law requires that the tite has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause	given in Part	I. 23	e. Did tobacc	o use contrib	ute to the	cause of death?	
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Record	law requas been 2 shoul	Completed						24	a. Was an autopsy	24b. We	ere autops	sy findings available pletion of cause of	à
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Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				2.71	e of Death (Chec	k only one)				
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		ion	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	V	njury at Work? □ Yes 2□		escribe how in	jury occurred	1		
Division	Attending Pt r death. sctor: After th by the funeral	fical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, str				cation (Street	and Number	or Rural I	Route Number,	-
Θ	after after Dire	Certification;	4 Homicide determined	building, etc. (Spec	cify)	,,,,		City	y or Town, Sta	2(e)			
	Hospitel or Attending 24 hours after death. Funerel Director: Afte tely filled in by the fune		29a. Certifier Check only 2 Medical Examin	ician: To the best of my k	nowledge, death	occurred at the	e time, date ar	nd place, and due	to the cause	(s) and manr	ner as stat	ted.	
	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th	Medical	one)	er: On the basis of examinand manner stated.	nation and/or in			ain occurred at th					
	To To	2	29b. Signature and title of certifier	- 1		290 100	ense number	1100	29d. E	Date signed (	Month, Da	ay, Year)	
,	2					1	27	100	09	1-02	- 6	004	
	9		30. Nome and address of person who co	mpleted cause of death (It	em 23a) (Type.	Print)	U.S.	200	AYN	non	1/cc	& Mr	)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	<i>M</i> -				1	5 P		_
	Registr	_	SEP 0 8 2004	Bleen D.	A DOM								

Physicia	an	1. Decedent's Name (First, Middle,			Puncat <del>e o</del> r i	Dealii	2. Date of Deat Month	h Day	Year	3. Time of
/Medic		Sheila Ort	SHELIA ANN	ORT			Aug.	29	2004	10:15
Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death	,	4c. Count	ty of Death	
			ryland Medical		13altim					
uneral		, , , ,	i.Sex 7. Age (II 1	n yrs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		9. Birthp	ace (State o try)
irector	-	220-52-9414 Usual Residence of Decedent		57 Yrs.			Mar. 4	, 1947	Mary	land
A sa	ŀ	10a. State 10b. County	10	Oc. City, Town or L	ocation				10	Od. Inside Ci
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28a-f show	Director	Maryland Harfo	ora	Bel Air	10f. Zip Code		11	0g. Citizen of	What Coun	tn/2
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ns 23a	Funerai	1201 Gyros Cou	12. Was Decedent Eve	r in U.S. 13	Was Decedent of H		ecify Yes or No-	14 Ba	USA	an Indian
r Items	뒫	1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		ack, White,	
II, or	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Speci	ify: Tath	ite
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tha	Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Sal	es Consul	tant		Furnit	ture S	tore
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in result and wental rygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wordical Examination in the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the continued and the cont	ToB	Glendon Lesl:	ie Wolford			Mary El	llen Swar	ın		
mar		19a. Informant's Name/Relationship	o (Type, Print)	19b. Mail	ng Address (Street a				n, State, Zip	Code)
tem 27 is		Larry G. Ort / H	Husband	1201	Gyros Co	urt, Bel	Air, MD	21014		
Item othe	- 9	20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date 2	20c. Location	- City or To	wn, State
y or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		-	matory or other plac on Cemete:		14	Darlir	arton	Mazazī
Important any injury once.	î	21. Signature of Funeral Service Li						Darlir	igcon,	Mary.
Important: If Ite any injury or of once.		Males (18	mape 1	]	2. Name and Addres	uneral Ho	me, P.A.	1/10	21014	
	-	23a Part1 Enter the disease or co	omolication that caused the	death Do not en	50 W. Broz	adway St.	or respiratory area	r, MD	21014	Approximate
2000	İ	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly ope cause on each line.	20		9, 50011 40 541 4145	or roopilatory arre	.51,		Interval Bety Onset and D
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Atter this certiticate has been signed by the attending physician and luneral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, and sequentially list conditions, cause. Enter Underlying Cause, (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co	onsequence of):  onsequence of):  onsequence of):  onsequence of):  oregnancy   Fetal death   3[	malforn    Ectopic pregnancy   Other (specify)	26. Place of Deater.  26. Place of Deater.  4  Nursing Howard Cater.  Yes 2 No  ne, date and place, pinion, death occur	24a. Was ar autops; perform 1 Yes 2 h (Check only one 5 Reside 28d. Describe hor City or Town, and due to the cared at the time, da	acco use con s 2 No 24b.  No nce 6 Ott w injury occur eet and Numi State)  use(s) and m te and place,	were autop prior to com death?  1   Yes    ther (Specify, rred)  ber or Rural  anner as stale and due to	Py Day Y e cause of dealth of the cause of dealth of the cause of dealth of the cause of dealth of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day 705cm **Physician** DWENS Sept UA 04 /Medical 4a, Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sing Ol UIT tome umbia 6. Sex 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Sountry) **Funeral** Days 1 □ M 2 X F Months Hours Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours efter death with the Maryler nent of Health end Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show ury or other traumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Funeral Director timor er 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 2 No Yes 2 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced ear or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keeper 18. Mother's Name (First, Middle, Maiden Syname) OX 17. Father's Name (First, Middle, Last) Be Whit ၉ mma 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) SOn Uepartment of Health en important: If item 27 is any injury --Bayner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 9/9/2004 4 ☐ Donation 5 ☐ Other (Specify) Memorial Kina tar 21. Signature of Funeral Service Licenses Home to. Md. 2/216 gral Ho Balto. tune W. North Ave. 23a. Part. Ther the diverse, or complications that be sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Peripheral Vascular disease

Type II Dia beter Mellitus Immediate Cause (Final disease or condition resulting in death) /Medical 6 morths Due to (or as a consequence of):

I Dia better Examiner Examiner buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Hyper tension ete hes been signed by the ettending physician pege 2 should be deteched for use es the burie Box 68760 by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chromic penal Pailure 24a. Was an autopsy performed? Completed certificete hes tu Yas 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA within 24 hours effer deeth.

To the Funeral Director: Affer this completely filled in by the funeral dir Certification: 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) m.D. 56531

Registrar

DHMH 16 Rev 6/95

State

Harry

Ridge Road

columbia.

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

HICKORY

32. Registrar's Signatur

10780

			1- State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Maryland / Department of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal State of Heal S	alth and M Ou tas	ental Hyg	iene	4 28349	
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	/Medic Examir	cal	GERARD A. PHILLIPS  4a. Facility Name (If not institution, give street and number)  Harbor Hospital Center  4b. City, Town, or Local Baltima	cation of Death	Septembe	4c. County o		_
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth	Vear	Birthplace (State or Foreign	n
7	Director		218-36-9826 68 Yrs. 68	lours Min.	(Month, Day, 11/3)	/3/5 1	MARYLAND	
	anyland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	the Maryla 28a-f shov notified at	ctor	MD N/A BALTIMORE				1 X Yes 2 No	
	or 28	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of Wi	hat Country?	
	death w	Funeral	1217 CHURCH STREET 2122		cify Ves or No-		SA - American Indian.	
936	after or Ite	ρ	Armed Forces? If Yes, specify Cuban, Me  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Mexican, Puerto F	Rican, etc.)		WHITE	
2-0	72 hours "naturel", vical Exe	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during	n most of workir	20	6b. Kind of Bus		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene tiem 27 Is marked other then "natu other treumatic event, the Warfall	Completed	Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER		.rg	TRUC	KING	
land	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  GEORGE PHILLIPS		(First, Middle, M MAY WH		)	
ary	should land Men s marke	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N	Number or Rura	l Route Number,	City or Town, S	tate, Zip Code)	_
	1 and 2 Health em 27 I		MRS. JOY KAHL/ DAUGHTER 7 DREW COURT	BALDW	IN, MD			
Baltimore,	permit. Pages 1 an Department of Heal Importent: if item 2 eny injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)				city or Town, State	
altir	permit. P Departme Importen eny injury		21. Signature of Funeral Service Licensee  22. APPENDED  23. APPENDED  24. APPENDED  25. APPENDED  26. APPENDED  27. APPENDED  28. APPENDED  28. APPENDED  29. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED  20. APPENDED	Y¦9/9/( k⊁acility⊞TINI)	NA LE	ME D /	DRE MD.	-
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7	Physician /Medical Examiner		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, sure shock, or heart failure. Lest only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sepsis  Due to (or as a consequence of):	uch as cardiac of	r respiratory arre	st,	Approximate Interval Between Onset and Death	
,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):					
8760,	ate phys	dical	d	<del> </del>				_
.O. Box 6	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown	-		23d. Date Monti	*	
rds, P	v requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in <b>Chronic Alcoholism</b>	Part I.	23e. Did toba	V	ute to the cause of death?  Probably 4 □Unknown	
Vital Records,	The faw ate has b page 2 si	Completed by			24a. Was an autopsy perform	pri	ere autopsy findings available or to completion of cause of eth? Yes 2 \( \subseteq \text{No} \)	
Vita	Physicien: T this certificat ral director, p	Be	examiner?		(Check only one		•	
of	g Phys er this eral di	1; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ne 5 Resider			-
ion	Attending r death. ector: After by the fune	atlor	1 Natural 5 □ Pending (Month, Ďaý Year) Injury Work? 2 □ Accident investigation M 1 □ Yes			, ,		
Division	n it to	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	81. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,	
	he Hospitel in 24 hours a he Funerel C	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, day one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	late and place, a n, death occurre	nd due to the cau ed at the time, dat	use(s) and mann te and place, and	ner as stated. d due to the cause(s)	
	To the h within 24 To the F complete	Σ	29b. Signature and title of certifier 29c. License num				Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	C.M.E.	Se	eptember	r 06, 2004	_
_		-coun	OL HALLAN WE 111 Penn Street, E	Baltimor	e, Mary	land 212	201	
:-	Sta Registi		SEP 0 8 2004  SEP 0 8 2004  Server Signature  Aparls					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ For	State of Maryland / De	partment of Heal	th and Mental F	łygiene	
	100		1 - Stete Registrar	С	ertificate of Dea	ath	Reg. No.	29350
	Physici	an.	Decedent's Name (First, Middle, Last			2. Date ofMonth	_	3. Time of Death
	/Medic		LONA	PIERCE		Septem	May 04 2004	12.201 M
	Examin	er	4a. Facility Name (If not institution, give	Calailibera-	4b. City, Town, or Loca	ation of Death	4c. County of Death	
			5. Social Security Number 6. Se			MG / A Inder 24 Hrs. 8. Date of	How,	
	Funeral Director			M 2K F Yrs	Months Days Ho		Day, Year) Cou	place (State or Foreign
			Usual Residence of Decedent	30		MACA	1 0. 1 /27 NOR	171 CAROLINA
	yland how		10a. State 10b. County	10c. City, Town or	Location	$\alpha$	,	10d. Inside City Limits
	a-fs	Director	MARYKAND NI	A	SALTIMO	RE CIT	y	1 XYes 2 □ No
	or 28	Olre	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show crivet be notified at		27 SOUTH		. 2	1227	USA	•
	er de items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hispan If Yes, specify Cuban, Me</li></ol>	ic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No- 14. Race - Americ Black, White,	
36	ours after death with the Marylar rat, or items 23a or 28a-1 show Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Sp	ecity:	Specify:	DO.K
5-0036	should be filled within 72 hours after Ind Menial Hyglene. marked other than "natural", or ite matic event, Ira Madical Examina	ed	15. Decedent's Edu	ucation 16a. De	cedent's Usual Occupation		16b. Kind of Business/In	dustry
215	hin 7:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) (G College (1-4or 5+)	ive kind of work done during a. DO NOT use retired)	most of working		,
21	d with giene. er thar	Com	12+MGRADE	N	URSES	AID	HOSPITI	44
D	ould be filed Mental Hygi arked other atic event, I	Be (	17. Father's Name (First, Middle, Last)			Mother's Name (First, Mid	dle, Maiden Sumame)	
<u>yla</u>	should but and Ment smarked	To	USCAR	HARRI.		ONA	CLAI	
Maryland	S S S		19a. Informant's Name/Relationship (T)		ailing Address (Street and N	lumber or Rural Route Nui	mber, City or Town, State, App	110
	s 1 and of Health item 27 other tr		USCARB. PIER	CE (SON) 27	Sposition (Name of	GTON AVE	BALTO. MD	21229
0	0 0 = =		20a. Method of Disposition  Burial 2 ☐ Cremation 3 ☐ F	cemetery, c	rematory or other place)	1	20c. Location - City or To	16.
altimore,			`4 □Donation 5 □ Other (Specify)	100000	-AWN (EME	109-10-04	WOODLAWN	MARYLAND
Ba	permit. Departr Importu any inj		21. Signature of Funeral Service Licens	1/1,21/1/2	22. Name and Address of	It. BROWN	WOODLAWN JR. FUNERI BALTO. MD.	42 HOME
			23a, Part1, Enter the disease, or comp	lications that caused the death. Do not	enter the mode of dving, sur	ch as cardiac or respirator	Varrest	Approximate
V.			shock, or heart failure. List only o Immediate Cause (Final	no cause on each line			on Digean	Interval Between Onset and Death
4	Prrysician /Medical		disease or condition resulting in death)	aDue to (or as a consequence of):	en ne con	40000000	on percon	
F	Examiner							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<ul> <li>Due to (or as a consequence of):</li> </ul>				
	cuted nd ransi	Examiner	that initiated events	C				
Ö,	e exe ian a urial-l		resulting in death) Last	Due to (or as a consequence of):				
8760	cate be executed physician and the burial-transii	dical		d				
တ		Med	IF FEMALE:	20- 16				
Вох	death certific e attending p id for use as	ian	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy		23d. Date of delive Month	ery Day Year
o.	D 00 D	Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		-	,
٦.	res that the de igned by the a be detached f	/ Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the	e underlying cause given in	Part I. 23e. D	id tobacco use contribute to the	ne cause of death?
g	uires sign ld be	d by	Diabete	, mellitus		11	☐Yes 2☐No 3☐Prob	pably 4 known
Ö	w require been significant	lete	Ensent	791 Hyperter	Bline .	24a. W	hs an 24h Were auto	psy findings available
Æ	The law requires that the sate has been signed by the page 2 should be detache	Completed	Chronic	0 11 1	2400	au	rtopsy prior to co prormed? death?	mpletion of cause of
Vital Records,		O	25. Was case referred to medical	racras back	26	l ☐ Ye		2   No
5	ysici is cer direct	o B	avaminar?	Hospital: 1 ☐ Inpatient 2 ER/Outpa	Othor		esidence 6 Other (Specif	v)
0	ig Ph ter th	n: T	27. Manner of Fath  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injur	of 28c. Injury at		e how injury occurred	,,
0	endir sath. or: Af he fur	atic	Accident investigation	(,,,	M 1 ☐ Yes	2 🗆 No		
Division of	or Att ter de irect n by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		n (Street and Number or Rura Town, State)	l Route Number,
	urs al urs al aral D			<u> </u>				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy (Check only one) Medical Exami	rsician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.	eath occurred at the time, da r investigation, in my opinion	ite and place, and due to t i, death occurred at the tim	he cause(s) and manner as s ne, date and place, and due to	tated. o the cause(s)
	o the ithin ; o the omple	Med	29b. Signature and title of certifier	and mainer stated.	29c. License num	nber	29d. Date signed (Month,	Day, Year)
	⊢ s ⊢ ŏ			ane	7308	641		
	W.		30. Name and address of person who con Ramer Sak	ompleted cause of death (Item 23a) (Tvi	pe, Print)	, 1	A II - A	1 /
V	h		Ramein Sak	cpathi 201- 109	Back River N	eck Kord	baltmore Me	ay (and 2/22)
		_	The Day Clark Charles Day Ward	00 8 - 1 - 1 - 01 - 1				

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2004

		•	For State Registrar	State of M	aryland	•	artment of rtificate of		ind Men		iene	4 28	351
	Physici /Medic		1. Decedent's Name (First, Middle, William Frank		11					Date of Death Month ptembe	Day	3. Tim Year 2004 1:3	e of Death
	Examin	er	4a. Facility Name (If not institution, Spa Creek Center	give street and number) Genesis El	der (		4b. City, Town, Annapo	lis		•	4c. County of	runde1	
	Funeral Director		5. Social Security Number 214-30-4747 Usuel Residence of Decedent	5. Sex 7. Ag	70	ast birthday) Yrs.	If Under 1 Yea Months Days		Min. (	Date of Birth Month, Day, 0/18/19		9. Birthplace (Sta Country) Maryland	te or Foreign
	Maryland -f ehow	tor	10a. State 10b. County  Maryland	•		,Town or Lo		-	-				City Limits
	with the 3a or 28e	Il Direc	10e. Street and Number 3620 West Garn	rison Avenue		CIMOI	10f. Zip Code 21215			10	U.S.A.	hat Country?	
336	n 72 hours after death with the Maryland -naturel; or Items 23a or 28e-f show	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces	Ever in U.S	57	Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race Black	- American Indiar k, White, etc. Black	1,
21215-0036	within ene. then	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or		16a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir dscaper	upation e during most red)	of working			Kind of Business/Industry ounds Keeper	
Maryland 2	be file ital Hyg id othe event.	To Be C	17. Father's Name (First, Middle, L William Pannell	ast)				Gertr	ude No	rris	Aaiden Sumame		
Mar	d 2 shoth and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and		19a. Informant's Name/Relationsh Essie Brown / I			1	ng Address <i>(Stree</i> Monroe S				-		
ē,			20a. Method of Disposition  1 XBurial 2 Cremation  4 Donation 5 Other (Sp		CE	emetery, crei	osition (Name of matory or other pi Cemetery		Date 0/09/20			City or Town, State	
Balti	permit. Page Department o Importent: If any injury or QDCE.		21. Synature of Funeral Service L	icensee								es F/H, aryland	
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Finel disease or condition resulting in death)	a.  Due to (or as	line.	Lu	er the mode of dy			spiratory arre	est,		Between nd Death
60,		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of Injury that initiated events resulting in death) Last	b. Due to (or as									
.O. Box 68760,	death certificate e attending phy od for use as the	Physician/Medic	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							-1.	23d. Date Mon	of delivery th Day	Year
s, P	juires that I n signed by uld be deta	by	Part II. Other significant conditio	ns contributing to death	but not resu	ulting in the u	nderlying cause o	given in Part I.		23e. Did tob		bute to the cause 3 ☐ Probably 4	
Record	The law requires that the rate has been signed by the page 2 should be detache	Completed								24a. Was ar autops perform 1 ☐ Yes 2	y pr ned? de	/ere autopsy findir rior to completion eath? □ Yes 2 □ No	ngs available of cause of
Vital	icien: certific rector.	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes ♣ No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatie	nt 3□ DOA C	ther	of Death (C)		ance 6 □Othe	r (Specify)	
on of	Te le	H	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of Inj (Month, D	ury	28b. Time o Injury	f 28c. In		28d.		w injury occurre		
Division	tel or Attending s after death. I Director: After ad in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of Ir	njury - At ho atc. (Specif)	ome, farm, st	reet, factory, offic	е	28f.	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medicel I	g Physicien: To the bes examiner: On the basis and manner s	of examina	wledge, deat tion and/or in	vestigation, in my	opinion, deat	d place, and th occurred a	t the time, da	ate and place, a	nd due to the cau	
	To t withi To ti	Ž	29b. Signature and little of Cartifler	Sums	>		1	3)	36		9/3/2	(Month, Day, Yea	r)
	IVAKS		30. Name and address of person	who completed cause of 2 (	death (Item	23a) (Type,	Print) Drive	che	when	Mo	2/60	9	
	Sta Regist		31. Date filed (Months Ca), Year	3 2004	rar's Signa	Nº A	المعرا						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9 Day Year Rosa Belle Pulley 1 2004 1:20a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care N.H. Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 3–14– Birthplace (State or Foreign Country)
 Va. **Funeral** Days 1 ☐ M 2 💢 F Months Hours 228-26-2392 78 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23e or 28e-f show other traumatic event, the Mcdical Examinar must be notified at 1 XYes 2 ☐ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 North East Ave. 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after I ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: 2 3 ₩idowed 4 Divorced Specify: Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ne any injury or other traumatic event and DEE. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKN Nursing Asst. J.H.H.17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Whitney Lee Nanney Winston ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra White 5238 Glenloch St., Philda., Pa. Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9-8-04 Holly Hill Cem. Middle River, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East Worn 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final rokes Physician disease or condition resulting in death) MO /Medical Due to (or as a consequence of) Examiner RISPILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events YU Due to (or as a consequence of): Examiner The law requires that the death certificate be executed DENTEMPEN ч resulting in death) Last Due o or as a consequence of): attending physician a P.O. Box 68760, u Physician/Medical Sch IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ____Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performe certificate ase referred to medical 2 🗌 No 1 Yes 2 No 1 Yas To the Hospitel or Attending Physicien: 25. Was case examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ů 1 ☐ Yes 2 2 ER/Outpatient 3 DOA B 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 18 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-1-04 D 24276 30. Name and address of who completed cause of death (Item 23a) (Type, Print) 2501 21224 9 31. Date filed (Month, Day 32. Registar's Signature State

DHMH 17 Rev 1/2001

Registrar

Elen & food

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			_ For	State of Maryland / I	Department of Health a	nd Mental Hygie	ne				
				#19a PER INF G83	Segtificate of Peath	Reg.	No2004 28353				
	Physici		1. Decedent's Name (First, Middle, Las		G.	2. Date of Death Sentemb	Day Year 9:25 M				
7	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of		4c. County of Death				
			5. Social Security Number 6. S	ed Kd. ex 7. Age (In yrs. last bii	nthday) If Under 1 Year / If Under 2	24 Hrs. 8 Date of Birth	Baltimore  9. Birthplace (State or Foreign				
	Funeral Director			MM 2□F 63	Yrs. Months Days Hours	Min. 8. Date of Birth Month, Day, Ye	1940 Maruland				
	pur *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Tow	m or Location		10d. Inside City Limits				
	Maryla -1 sho	to	Maruland Balt	Fimore	NIA		1 XYes 2 No				
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ita Medical Exacting mast be notified at	Funeral Director	10e. Street and Number	· (: 11 D1	10f. Zip Code	10g.	Citizen of What Country?				
	ns 23a	eral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Orig	tin? (Specify Yes or No-	14. Race - American Indian,				
9	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican,  1 ☐ Yes 2 No Specify:	Puerto Rican, etc.)	Black, White, etc.				
215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	•	400	Specify: Black				
215-	hin 72 an "nai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Cetterne (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most life. DO NOT use retired)	of working	b. Kind of Business/Industry				
21	filed with Hygiene. other ther	Сош	12	O AS	ssembly Line		eneral Motors				
Maryland	ould be fill Mental H arked ott atic even	) Be	17. Father's Name (First, Middle, Last)	Alley	18. Mother	r's Name (First, Middle, Mai	den Sumame)				
aryi	2 should and Men is marke	ို	19MRS. ALTCE PULLEY	Type, Print) (wife) 19th	. Mailing Address (Street and Number	r or Rural Route Number, Ci	ity or Town, State, Zip Code)				
	1 and 2 Health a tem 27 is		Mrs. Alice Y	ully 1	708 Yakona	Rd. A B	alto.Md. 21234				
Jore	8° = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State cemete	f Disposition (Name of ry, crematory or other place)	311	Location - City or Town, State				
Baltimore,	artn orts inju		* 4 □ Donation * 5 □ Other (Specify  21. Sigpeture of Funeral Service Licen	71 20	22. Name and Address of Facility	7/13/2004	paito.IVIa.				
ä	permit. Departimport eny inj		Joseph	L. Kuss	Joseph L. Rus: 2222 W. North	Ave. Balt	tome 0.Md. 21216				
			23a. Parti Enter the disease, or comp shock, or heart failure. List only		not enter the mode of dying, such as o	cardiac or respiratory arrest,	Approximate Interval Between Onset and Death				
8	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	, , , , , , , , , , , , , , , , , , , ,	inal ble	edity Onset and Death				
2(	Examiner		Sequentially list conditions,	· Oesophe	ageal Var	ulep	O				
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):)  Of 1874 (200 S) C Of 1874 (200 S)							
,		Examine	that initiated events resulting in death) Last	Due to (or as a consequence							
8760		dlcai	(	, d							
9	leath certific attending pl	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			201 5-1-1/1-1				
Box	death of atten	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death	23d. Date of delivery  Month Day Year						
P.0	that the de led by the a detached	Phys	9 Unknown	9□ Unknown							
	uires the signed Id be d	þ	Part II. Other significant conditions of	shension but not resulting i	n the underlying cause given in Part I.	1 ☐ Yes	co use contribute to the cause of death?  2  No 3 Probably 4 Unknown				
Vital Records,	aw require s been sig 2 should b	Completed	Cong	estive He	east rae 1	24a. Was an	24b. Were autopsy findings available prior to completion of cause of				
I Re		Com	Ó			autopsy performed 1 ☐ Yes 2 🔀	? death?				
Vita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:	Othor	of Death (Check only one)					
of	를 글 글	n: To	1 ☐ Yes 2 ②No 27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	sing Home 5 Residence 28d. Describe how i					
sion	- Z - =	atio	1 Natural 5 Pending 2 Accident Investigation	1	Injury Work?  M 1 Yes 2 N	ło					
Division	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certitier 1 Certifying Ph	ysician: To the best of my knowledge	e, death occurred at the time, date and or investigation, in my opinion, death	place, and due to the cause	e(s) and manner as stated.				
	the H thin 24 the F mplete	Medical	one)  29b. Signature and title of certifier	and manner stated.	29c. License number						
	7 × 0			seedi MD	D267-	48 9	Date signed (Month, Day, Year)				
i	n		30. Name and address of person who		(Type, Print)	RA RA	170.MD 910.0				
	Sta	to	31. Date filed (Month, Day, Year)	Registrar's Signature	tola 1-ALLS	190 1011	1 20000				
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				1 - For State Registrar	State of	of Maryl		partment of F partificate of I			giene Reg. N. 0 ()	Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of th	28354
		(e a		1. Decedent's Name (First, Middle	, Last)			-		2. Date of Dea	ath	,	3. Time of Death
		Physici /Medi			Ph	ilip A.	Quino	nez		Month	Day Sep 1, 2004	Year	7:27 Pm. M
-		Examir		4a. Facility Name (If not institution					Location of Deatl				
				Hospice	Of Baltimore	(Gilchrist	Center)		Tov	vson		Baltir	nore
		Funeral		5. Social Security Number	6. Sex		yrs. last birthday		If Under 24 Hrs.	8. Date of Birti	h Voor)	9. Birth	place (State or Foreign ntry)
		Director		213-20-0769	1 <b>→</b> M 2 □ F		83 Yrs.	Months Days	Hours Min.	Nov 13			San Wan
		PC ,		Usual Residence of Decedent									
2		anylar show	_	10a. State 10b. County		10c.	. City, Town or I	Location					10d. Inside City Limits
8		h the Maryland r 28a-f show	cto	Maryland	N/A							_	1 ☐ Yes 2 ☐ No
N		or 2	Jir.	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cou	ntry?
4		23a	la	630 St. Anns Ave.					21218			U.S.A	<b>A</b> .
7:2		filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-f show ant, the Medical Examirer must be mailified at	Funeral Director	11. Marital Status	12. Was Dec Armed F	cedent Ever in orces?	n U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		- Ameri	can Indian,
	36	or if	by Fi	1 Never Married 2 Marri	If Yes, G	ive No		1 Yes 2 No	Specify:	, ,	Specify:		
	5-0036	72 hours natural',		3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:					Spoury.		spanic
1	5	in 72 ho	Completed	15. Decedent (Specify only highes	's Education <i>t grad</i> e co <i>mpleted,</i>	)	16a. Dec (Giv	edent's Usual Occup: e kind of work done o DO NOT use retired	ation during most of wor	rking	16b. Kind of Bu	siness/In	dustry
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2004		e filed of Hygie other t	ပိ	12 17. Father's Name (First, Middle, I	act			1100		no (Final Ministra	Maidan Coma	- 1	
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1.	Maryland	s 1 and 2 should be f if Health and Mental I Itam 27 is marked or other traumatic eva	2	19a. Informant's Name/Relationsh			10h 14ai	lin - Address (Otrost					
8	Ma	d 2 sin and 7 is traur						ling Address <i>(Street a</i>				state, Zip	Code)
36		1 and 2 Health tarm 27		Sonia M. Quinonez 20a. Method of Disposition	Daugnter	201		position (Name of	ve. Dalumon			Tibe or Te	Ctata
3	ŏ	in of long or o		1 ☐ Burial 2 🔀 Cremation			cemetery, cri	ematory or other plac	θ)		20c. Location - (	•	
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SEPTEMBER	Baltimore,	permit. Pages I Department of H Important: If Ita any injury or ot		21. Signature of Func all Service L	Icensee		1	22. Name and Addres		val Homo D	۸		
8		TD = 6 0		Cely 4 ra	194			1300 Eu	itaw Place E	eral Home P. Baltimore, Mi	21217		
J				23a. Part 1. Enter the disease, or shock, or heart failure. List of							rest,		Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition		1 AXi	Clary	Sinvs	CANCI	e 12		F	Onset and Death
		/Medical Examiner		resulting in death)	Due to	(or as a cons	sequence of):						
	н	xammer	-	Sequentially list conditions,	b								
		or sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	sequence of).						
.)		ecute and -tran	саш	that initiated events resulting in death) Last	c.							_	
S	90	icate be executed physician and s the burial-transil	E		Due (0	(or as a cons	sequence of):						
	68760,	the b	edlcal		d								
			Me	IF FEMALE:	20. 11								
	Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		birth 2 🗆 F	etal death 3	☐Ectopic pregnancy			23d. Date Mon		ory Day Year
		the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregi 9☐Unkn	nant at time o lown	of death 5	Other (specify)			IVIOITI	ш	Day real
8	P.0	d by	Physiclan/M				dat t ab						
17	S	The law requires that the death certif tle has been signed by the attending page 2 should be detached for use an	by	Part II. Other significant condition	ins contributing to o	eath but not	resulting in the	underlying cause give	и и гап I.		4		ne cause of death?
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	H	The l	ő							perform 1 ☐ Yes	ned? de	ath?	
2	<u>it</u> a	iysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only on	<del></del>		1
70		S 50 D	To:	1 ☐ Yes 2 No	Hospital: 1 🗆	Inpatient 2	P ☐ EP/Outpatie	ent 3 DOA Othe	er: 4 🗍 Nursing Ho	ome 5 Reside	ence 6 X Other	(Specify	Hospice
UINONE	0	Attanding Physician: r death. actor: After this certifica by the funeral director. F	i.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year	28b. Time (	of 28c. Injury Work		28d. Describe ho			1,12-1
3	.0	ttandii death. stor: A	atle	2 Accident investig	ation				res 2 □ No				
77	Division of Vital Records,	er de racto	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 288. Place	of Injury - Aing, etc. (Spe	t home, farm, s	treet, factory, office		28f. Location (St City or Town	reet and Number	or Rura	l Route Number,
3		talors aft	Cer			, (-,	,,			ony or your	i, blato)		
		To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	cal	29a. Certifier 1 Certifying	Physician: To the	e best of my h	knowledge, dea	th occurred at the tim	e, date and place,	, and due to the ca	ause(s) and man	ner as st	ated.
		the H iin 24 the F plete	Medical	one)	and man	ner stated.	mation and/of i	nvestigation, in my op	imiori, death occur	rea at the time, d	ate and place, ar	id due to	tne cause(s)
		To t To t	Σ	29b. Signature and title of certifier	1 -1			29c. License			9d. Date signed		
		1		> 9/ Hathen	y they	, mo		025	200		Septemb	er a	,2004
		1		30. Name and address of person w	vho completed caus	se of death (I	tem 23a) (Type	, Print)	1				
				00 173	GBMC 6	701 N	1. Chan	les St. Bu	lita Md	2126,	)e		
		Sta Registr		31. Date filed (Month, Day, Year) SEP 0.8	2004	egistrar's Sig	gnature						

State of Maryland / Department of Health and Mental Hygiene 1- State AMEND ITEM #5 PER FH G835 9/14/Destificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Sept. 6, Stanislaw Rausch 2004 1:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Riverview Care Center Essex Baltimore 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Poland Poland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs 91 Director 219-30-8920 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 South Kenwood Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No White Specify: δ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Butcher permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th any injury or other traumatic event, the ODGs. Meat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ignat Rausch Anna Bierlein 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1168 Bethany Beach, Delaware 19930 Bozenna D. Eastburn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 9/10/2004 Baltimore, Md. A □ Donation 5 □ Other (Specify) 22. Name and Address of Facili Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Poles 1201 Dundalk Avenue Baltimore,Md 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadsoon each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician neurona 1 leeek /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ulsease or irriury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and the for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, pe Morie tet acture Polorman Drace 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed prioscleratic Cornaus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 24 No certificate has Acordent old Regalrounceston 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one. examiner' Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide We Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09-07-2004 DIS6607 Mucaria Lucel 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

0 8 2004

Michael Schwartz, M.D. 7310 Ritchie Hwy, Suite 508 Glen Burnie, Md. 21061

			for State Registrar	State of Maryland	Department of Health and Certificate of Death		Mental Hygiene				
	Physici		1. Decedent's Name (First, Middle, I	e E. Rider	out	2. Date of Death	0-04	3. Time of Death			
Port.	/Medio		4a. Facility Name (If not institution, s Convey Br 5. Social Security Number 6	ive street and number) i dge NWSing}	4b. City, Town, or Location of De Bulting birthday) If Under 1 Year   If Under 24 H	ore	4c. County of Death	ace (State or Foreign			
	Funeral Director	å	Usual Residence of Decedent	1 M 2 MF 86	Yrs. Months Days Hours M	in. Month Day, Yo	18 Mar	State or Foreign			
	e Marylan Sa-f show	ctor	10a, State 10b, County	Bo	own or Location  Utimore			od. Inside City Limits 1			
	ath with th	ral Director		aven Blud Apt	B 21286		Citizen of What Coun				
5-0036	72 hours after death with the Maryland naturel', or items 23e or 28e-f show dissa Examinse must be notified at	d by Funeral	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 — No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e				
21215-(	within 72 ene. than "nai	Completed	15. Decedent's (Specify only highest ( Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most during most dur	vorking 16t	MiWiS	ustry Hry			
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re, Mary	1 and 2 s Health ar em 27 ls ther trau	1	19a. Informant's Name/Relationship	Hock (SON)	9b. Mailing Address (Street and Number or 8205 Lochrosof Disposition (Name of	Rural Route Number, C	ity or Town, State, Zip  Date:  Location - City or Tow	Code)			
Baltimor	nit. Page artment o ortant: If injury or is.		1 ■ Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Special Service Lice)	city) New	Stery, crematory or other place)  Coffe drul (eneter)  22 vigo energings (Facility de	13/04 7	Balto. N serul Ser	1D vices			
Ä	Per Dep Imp		23a. Part1. Enter the disease of coshock, or heart failure. List on	<b>Stellne</b> mplications that caused the death. E	4903 Use K	. Rcl · Ball iac or respiratory arrest,	to MD 2	Approximate Interval Between			
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of deliver Month	ry Day Year			
	quires that n signed by	by	Part II. Other significant conditions  August Plumpung	contributing to death but not resulting	g in the underlying cause given in Part I,	23e. Did tobac	co use contribute to the	e cause of death?			
Vital Records,	The law require ate has been sip page 2 should t	Completed	Rigo Demen	ein pailiere to	dru HOUD	24a. Was an autopsy performed	prior to com death?	sy findings available ipletion of cause of			
Vita	Physician: The la r this certificate hai rral director, page 2	o Be	25. Was case relerred to medical examiner? 1 ☐ Yes 🔊 🗂 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	lan t-	leath Check only one					
n of	ge fa	<del> </del>	27. Manner ol Death 1 ☑Natural 5 ☐ Pending		b. Time of linjury 28c. Injury at Work?	28d. Describe how i					
Division of	or Attendi	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be One Class of Laive, At home	M 1 Yes 2 No	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,			
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical Ce	29a. Certifier (Check only one)	Trysician. To the best of my knowled aminer: On the basis of examination and manner stated.	Jge, Jeath occurred at the time, date and pla and/or investigation, in my opinion, death oc	co, and due to the causicurred at the time, date	e(s) and manner as sid and place, and due to	iteu. the cause(s)			
	To the within To the complex	Me	29b. Signature and title of certifier		29c. License number	I .	Date signed (Month, D	*			
				Mulmillo; MD completed cause of death (Item 23)	D545/8	9-	1-2004				
	4		MANTHA RAUMUN	IDU 5601 LOCK R	WEN BILLD BALTMONE	m021237		7)			
	Sta	ite	31. Date liled (Month, Day, Year)	32. Registrar's Signature	4 1 4						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylar	nd / Department of Certificate			ene	28257
	Dhysia		1. Decedent's Name (First, Middle, Last	)	0 - 1 -		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		BETTY		REDD	) 	SGP-GAB	A 3 2004	14:288M
	Examir	ner	4a. Facility Name (If not institution, give	1	4b. City, To	wn, or Location of Deat	h	4c. County of Death	
	*	Ш	SINAI I	TOSPITAL	- 13	ALTIMO!		NI	A
	Funeral Director		5. Social Security Number 6. Se 216-34-6539	X 7. Age (In yrs.	/ Ast birthday) If Under 1 \ Months D	Year If Under 24 Hrs Pays Hours Min.	8. Date of Birth		place (State or Foreign intry)
	D		Usual Residence of Decedent	10.00			1,00.00,1	707 177	
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Eventrating the rollified at	5	10a. State 10b. County	10c. Ch	ty, Town or Location	- 11- 0	- 1	-,/	10d. Inside City Limits 1
	28a-f	Funeral Director	10e. Street and Number	IA	10f. Zip Co	TIMOR		Citizen of What Cou	
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	death ms 2	era	11. Marital Status	12. Was Decedent Ever in U		t of Hispanic Origin? (S Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ameri	
9	after dea or Items	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No II Yes, Give	If Yes, specify		o Rican, etc.)	Black, White	etc.
5-0036	hours after tural; or Ite	d by	3 ☐ Widowed 4 🌂 Divorced	Year or Dates:				Specify: BL	ACK
	"nate	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use r	done durina most of wor	rking 16	b. Kind of Business/Ir	ndustry
121	filed within Hygiene. other than "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	BEAL 2	TICIAN	/	SEIEE	MPLOYED
d 2	Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)	<u> </u>	NEMUT		ne (First, Middle, Ma		MALUYED
Maryland	ould be Mental larked o	To B	WILLIE	SH	AW	AUGU	STA P	ROBI	NSON
lary	and N and N is ma		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Address (S.	treet and Number or Ru	ıral Route Number, C	ity or Town, State, Zi	o Code)
	and and m 27		JODIE KANDAL	L (DAUGHTER,	1996051	OSHANE		MOALLSTOU	W MO.21133
ore	iges 1 nt of H : If itel		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition (Name cometery, crematory or other	of r place)	Date / 20	c. Location - City or T	own, State
Baltimore	permit. Page Department o Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify)	DA	LUIDRIDGE	EME 09- 0	59-04 P	KESVILL	E, MARYLAND
Bal	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Licens	1/1. ) 11.	22. Name and A	Address of Facility	BROWN	TR. FUNE	RAL HOME
			23a. Part1. Enter the disease, or comp	ications that caused the deat	h. Do not enter the mode of	O FULT		YSALTO, M	O. 21217 Approximate
	No.		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conseq	10 CARCINOMA	+ OF THE	LUNG		QUEEKS
	Examiner				001100 017.				
	D F	ner	if any, leading to immediate	b. Due to (or as a conseq	uence of):				
	ecuter and trans	Examiner	cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	C					
760,	be exectan a		resulting in death) Last	Due to (or as a conseq	uence of):				
•	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		d					
9 x	certifi iding ise as	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incv			and Date of deliver	
Вох	leath atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 ☐ Ectopic pregn			23d. Date of delive Month	Day Year
P.O.	that the death cer ed by the attendir detached for use	hysi	1 ☐ Yes 2 <b>ゑ</b> No 9 ☐ Unknown	9□ Unknown					
	w requires that s been signed b should be deta	by P	Part II. Other significant conditions co		ulting in the underlying caus	e given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Division of Vital Records,	en sig	Completed by	HYPERTEN				1 🗆 Yes	2 No 3 Prot	pably 4 Unknown
ecc	faw ra as be 2 sh	ple	HyfERLi	PIDEMIA			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause ol
<u>=</u>		Con	CERCI	300 VASCULAR	ACCIOGNI		performed 1 ☐ Yes 2 🖫	? death?	2 No
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	7		26. Place of Dea	th Check onl one		
of	Physical this cal dir	2	1 ☐ Yes 2X No  27. Manner of Death		ER/Outpatient 3 DOA 28b. Time of 28c.	Other: 4 Nursing H	ome 5 Residenc	e 6 Other (Specif	(y)
UQ	ding Phys h. After this funeral di	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
İSİ	l or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, larm, street, lactory, of		28f. Location (Stree	t and Number or Rura	Il Route Number
D	alor / after I Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify	y) -,,,,,,,,,		City or Town, S	tate)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Exami	sician: To the best of my kno	wledge, death occurred at the	he time, date and place	, and due to the caus	e(s) and manner as s	tated.
	the H iin 24 the F	ledical	0.00	ner: On the basis of examina and manner stated.			rred at the time, date	and place, and due to	the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	er M.D.		cense number		Date signed (Month,	
			)(.)	1		0-22609	SE	PORMBER	3 2004
	4		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type, Print)  FURVACE BRA	an Ad A	0.0	- Not -	2101 -
	Sta	te:	RUBEN RE'DER  31. Date filed (Month, Day, Year)	32. Registrar's Signa	TURNACE BLA	WCH KU-6	LEN BURNI	C 1700 2	1060
51	عاد Registr		SEP 0.8.2004	beneva 1	9 Sports	1			

			1 - For State of Registrar	Marylan		artment of F	lealth and M		0001	0.0.0
			Hegistrar  1. Decedent's Name (First, Middle, Last)		061	illicate of	Dealli	2. Date of De	Reg. Not	3. Time of Death
	Physici /Medic			man J.	Raym	an	\$	Month	3 2004 Year	1:45a M
	Examin		4a. Fecility Name (If not institution, give street and num	,		4b. City, Town, o	r Location of Death		4c. County of Dea	th
			311 Carroll Island F				ys Quart	ers	Baltimo	re
	Funeral Director		5. Social Security Number 6. Sex 1 1 2 4 6 - 5 7 5 1 1 2 M 2 F	7. Age (In yrs. I 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov. 1	y, Year) Co	thplace (State or Foreign cuntry) ryland
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c Cin	y, Town or Lo	nation				
	Maryla f sho	ŏ	MD Baltimore	100. 011)	y, 10411 0/ LO		ys Quart	ers		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code	ys Quare		10g. Citizen of What Co	
	h with	Ö	311 Carroll Island F	≀oad			220		USA	
	deat	ner	11. Marital Status 12. Was Deced	dent Ever in U.	S. 13. V		lispanic Origin? (Spe an, Mexican, Puerto F	city Yes or No-	14. Race - Ame	
98	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show he Madical Examinar must be notified at	Completed by Funeral	1 Never Married 2 Married 1 Yes :	2 □ No e		☐ Yes 2☐No	Specify:	nican, etc.)	Black, White Specify: White	
Ö	hours tural'	d be	3 ☐ Widowed 4 ☐ Divorced Year or Da	tes:						
7	in 72 n "na Nedic	piet	(Specify only highest grade completed)		(Give	ent's Usual Occup kind of work done o O NOT use retired	etion du <i>ring most of workin</i> d)	ng	16b. Kind of Business/	Industry
21215-0036	d with giene ar tha	mo	Elementary/Secondary (0-12) College (1- 12th	4or 5+)		ntenanc			VA	
D D	al Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
<u>ya</u>	ould to	2	Andrew L. Rayman				Mae Oke			
Maryland	12 sh h and 7 Is m traum	0 8	19a. Informant's Name/Relationship (Type, Print)  Judy Rayman / wife						or, City or Town, State, 2	
	1 and Healt em 2		20a. Method of Disposition	20b. Pl	lace of Disno	ition /Nama of	D.	Road	Baltimore	
or I	ages ant of it: If it		13 Burial 2 ☐ Cremation 3 ☐ Removal from S  '4 ☐ Donation 5 ☐ Other (Specify)	tate Oal	emetery, crem K Lawi	n Cemete	ery 9/8		Baltimor	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any pincy or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Licensee					11B		
Ö	Depa Impo any it	7 1	X Terry Con	ulle	1	300 Mac	e Ave. I	lellyr Baltim	uneralHom ore MD 21	221
Н			23a. Pert1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death	00 not ente	r the mode of dyin	g, such as cardiac or	respiratory arr	rest,	Approximate Interval Between
	Priysician	0 3	Immediate Cause (Final disease or condition	una (	Conce	1				Onset and Death
	/Medical Examiner		resulting in death)  Due to (death)	or a consequ	ence of):	-				10 1111111
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (o	or as a consequ	ience off:					<del></del>
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or in ju.) that initiated events	-						
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38760	icate be executed physician and s the burial-transit	dicai	d							
~		/Mec	IF FEMALE:			_				
Вох	death certifi e attending id for use as	Physician/Me	III the past 12 months?	ome of pregnan th 2 □ Fetal int at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
o.	0 0 0	ysic	1		aui 5	Other (specify)				
υ, Ο	res that igned b be deta	by Pl	Part II. Other significant conditions contributing to dea	ath but not resu	liting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ecords,	law requires that the as been signed by th 2 should be detache							1 <b>2</b> (Y	es 2□No 3□Pro	bably 4 Unknown
ဝင္ပ	law re as be 2 sho	Completed						24a. Was a	n 24b. Were aut	topsy findings available ompletion of cause of
Υ —	The lav	Con						perform	med? death? 2 No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1				26. Place of Death			
o	hys his	5	1 ☐ Yes 2 No Hospital: 1 ☐ Inj  27. Manner of eath 28a. Date of		PVOutpatient 28b. Time of	3 DOA Othe	4   Nursing Hom		ence 6 Other (Spec	ify)
0	Attending I r death. ector: After by the funer	tion		, Day Year)	Injury	Work	res 2 □ No	od. Describe ric	ow injury occurred	
Division	al or Attendi atter death. † Director: A d in by the fu	iffica	3 Suicide 6 Could not be	of Injury - At hor	me, farm, stre	et, factory, office		of. Location (St	reet and Number or Ru	ral Route Number,
	spital or ours afte neral Dir filled in	Certification:	4 _ Normode building	g, etc. (Specify)	,			City or Towr	n, State)	
	Hospi 4 hour Funer Fely fill	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the base and of anne	sis of examination	viedge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place, an inion, death occurred	nd due to the ca	ause(s) and manner as a ate and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	. stated.	1	29c. License			9d. Date signed (Month,	
			Valua Clilation	/ul	no	1	27356	7	Sestember	3 2m 4
	·n.		30. Name and address of person who completed cause	of death (Item	23a) (Type, P	rint) Fran	the Sa	uore H	September	1-4/
	13		31. Date filed (Month, Day, Year) 32. Reg	Distrar's Si	9	deo la	roll S	gen 1	& Bolt	21237
	Stat Registra		SEP 0 8 2004	gistrar's Sideatu	Appel					

			1 - For State Registrar	State of M	aryland /	•	irtment of H tificate of L			iene _{eg. N} g. (	104	28359
	Discontint		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Barbara		Sav	age			September	6	2004	8:30AM
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, or		h	4c. C	ounty of Death	
	- Formula		3924 Bareva R 5. Social Security Number 6. S		e (In yrs. last	birthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		•	place (State or Foreign
h	Funeral Director			□M 2ØF	62	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	2 Cou	ntry) NC
	pu		Usual Residence of Decedent  10a. State 10b. County		10- Cit. T		- 41					104 1-14-01-11
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	or	10a. State 10b. County	Δ	10c. City, To	_	cation TIMDRE					10d. Inside City Limits 1    Yes 2   No
	28a-f	Director	10e. Street and Number	1		D4C	10f. Zip Code	,		Og. Citize	n of What Cou	
	3a or		3924 Bareva 1	Zoad				21215		-3	USA	,
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	ffy Yes or No- can, etc.) 14. Race · American India Black, White, etc.		
36	or ite	y Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ If Yes, Give	No	1	Yes 2 No	Specify:	o mean, etc.)	s	pecify: BL	
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	110	Sa Decec	ent's Usual Occupa	ution			of Business/Ir	
15	in 72 n "na Neulic	Completed	(Specify only highest gra Elementary/Secondary (0-12)			(Give	kind of work done a OO NOT use retired,	luring most of wor	rking			
212	d with giene er tha	Com	11th grade	N/A	5+)	DAY	CARE P	POVIDE	R	<u> </u>	+(11)	CARE
nd	should be filed withir and Mental Hygiene. marked other than matic event, the Ma	Be	17. Father's Name (First, Middle, Last,						me (First, Middle,			
ryla	d Men narke natic	To	Stephen Inc			Ob. Mailine	- 4 / (00 4 4		ude (			
Maryland	id 2 should lith and 27 is m. traum.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Parl H. Savage/Husband 3924 Bareva Rd. Bo							-		
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition	J	20b. Place	of Dispo	sition (Name of natory or other place				ition - City or To	
E	Page nent o ant: If ury or		1 💆 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specil						13.041	Wir	JGS M	ILLS, MD
Baltimore,	permit. Pages Department of Himportant: If ite any injury or of Once.		21. Signature of Feneral Service Lice	nse		22 V/	Name and Address AUGIHN C.	s of Facility  CREENE	FUNER	ALS	ervic	es 1229
	= =		23a. Part1. Enter the disease, or com shock, or neart failure. List only	plications that caused	the death. D	o not enti	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Polit Z	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		monia							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):						
	xariiiioi	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	e of):	etastatic	to bra	in			2 years
	uted d ansit	mlne	cause. Enter Underlying Cause (Disease or injury that initiated events  C.								1	
oʻ	cate be executed physician and the burial-transit	Examln	resulting in death) Last									
38760,	icate be executed physician and s the burial-transit	dlcal		d								
~			IF FEMALE:							7		
Вох	law requires that the death certific as been signed by the attending t 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea		Ectopic pregnancy Other (specify)			230	ery Day Year	
O.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	tuno or douts	3_	Other (specify)					
ם` מ	res that igned b	by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulting	g in the ur	derlying cause give	n în Part I.	23e. Did tol	acco use	contribute to the	he cause of death?
ord	w require been sig should b								1.8 Y	s 2 🗆 1	No 3 ☐ Prot	pably 4 □Unknown
Records,	e law r has be ge 2 sh	Completed							24a. Was a autops	v l	24b. Were auto	psy findings available impletion of cause of
E	ate pag	Con							perform 1 Tes	ned? 2 ☑ No	death?	2 No
Vital	Physician: Th r this certificate ral director, paç	Be c	25. Was case referred to medical examiner?	Hospital:			Othe		th (Check only on			
of	ding Physician: h. After this certific funeral director,	To To	1 ☐ Yes 2 Z No  27. Manner of Death	28a. Date of Inju	ry 28t	. Time of	28c. Injury Work	at Nursing H	ome 5 Reside			y)
on	ath. r: Afte	atlor	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury		? ′es 2 □ No				
Division of	il or Attending after de ath. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not b		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		lumber or Rura	il Route Number,
Ω.	ital o rs aft ral Di led in			1								
	To the Hospital or Attant within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example	nysician: To the best niner: On the basis o and manner st	examination	lge, death and/or i <i>n</i> v	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, d	tuse(s) an ate and pl	ed manner as so ace, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License		2		igned (Month,	
)	7,		L. Questin	Dayle "	10		02	3809		Sep	tember	7, 2004
	(		30. Name and address of person who L. Austra Doyle,	M.D., Gree		-	encer Ctr	., 22 5.	Grean !	T+-,	Baltimo	~, MO 21201
	Sta Registr			32. Regis								, , , , , , , , , , , , , , , , , , , ,

			For State Registrar	State of Maryla	-	ertificate of		•	giene	ΩL.	28360
ı	Physici	an	Decedent's Name (First, Middle, Last	STERN				2. Date of Dea	Day_	Year	3. Time of Death
>	/Medic Examin	al	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat		4c. Cour	2001	4:10 A ^M
	E Xallill	C1	221 CARROLL	RD		PASAT	A AUGO	AD SIIS	2	A.A.	CO.
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs		Months Days	If Under 24 Hrs Hours Min.	(Month, Da	h v, Year)	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	82	) 113.			05/14	/1922		PA
	nyiand thow		10a. State 10b. County	10c. C	ity, Town or I	ocation				1	0d. Inside City Limits
	Be-f	Funeral Director	MD Anne Ar	undel I	asade				10. 07	/11/1	1 Tes 2 No
	with the	Dire	10e. Street and Number 221 Carroll Ro	d		10f. Zip Code 21122			10g. Citizen o		itry?
	death	nera	11. Marital Status	12. Was Decedent Ever in	J.S. 13	. Was Decedent of H		pecify Yes or No		ace - Americ	
36	be filed within 72 hours after death with the Maryland Ital Hygiene od other than "natural", or Items 23a or 28e-f show event, I'ra Medical Exeminal rusat be mellified at	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ No 1 9  If Yes, Give Year or Dates: 1 9	945 <b>-</b> 948	1 ☐ Yes 2 No		to Hican, etc.)	Spec	lack, White, cify: Wh	ite
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dec	edent's Usual Occup	pation during most of wo	rkina	16b. Kind of	Business/Ind	dustry
12	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			II C	Conn	t Guard
	filed v Hygie other t	ဝ	10 17. Father's Name (First, Middle, Last)		Merc	der Fore		me (First, Middle,			C Guaru
a	b d la b	To Be	Dewey Stern				Rose	Miller			
Maryland	s 1 and 2 should if Health and Men item 27 is marke other traumatic	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ling Address (Street	and Number or R	ural Route Numbe	r, City or Tow	m, State, Zip	Code)
Σ «	1 and 2 Health Iem 27 I		Dorothy Stern			Carroll		Pasade			
Baltimore,	permit. Pages 1 Department of He Important: If iter any injury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3	Hemovai from State		position (Name of ematory or other pla	1		20c. Location		
=======================================	artmer artmer ortant injury		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Len Ha	aven Mem 22. Name and Addre	PK 09/	J Gong	Glen B	Burni eral	e, MD
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	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the decone cause on each line.	ATIC		ng, such as cardia		rest,	IND	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Que to (or as a conse		TRIERY ?	DISEAS				
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	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
760,	sician buria	calE	South (of as a consequence sty).								
9	g phy as the	=		0.							
Box	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of	al death 3	☐Ectopic pregnanc	у			Date of delive Month	ry Day Year
0	at the c by the tacher	hys	9 Unknown	9□ Unknown							
	The law requires that the site has been signed by the bage 2 should be detache	by F	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	ven in Part I.		obacco use co 'es 2 No		ably 4 Unknown
Division of Vital Records,	w require been sig should b	Completed by	Triper ciproci	***************************************							
Rec	has las	ldm						24a. Was autop perfo	sy rmed?	prior to cor death?	osy findings available appletion of cause of
ta	en: Ti lificate or, pa	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 🗆 Yes	2 No
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0	ng Ph fter th ineral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo		28d. Describe h	ribe how injury occurred		
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Σ	al or A after of I Direct	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	ify)	street, factory, office		City or Tow		nder or Aura	House Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 15 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, dea	ath occurred at the tinvestigation, in my	me, date and place opinion, death occi	e, and due to the curred at the time,	cause(s) and r date and place	manner as st e, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	110		29c. Licens			29d. Date sign	ned (Month, I	Day, Year)
1	X		· Varcel			1) 00	58368		09-	03-	04
	15		30. Name and address of person who	completed cause of death (Ite		e, Print)	100 01	10 On	- 400	14	110 5
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi frar's Sign	EDW)	ing KAIL	108 B/1	N PA	SHIDE	VIA,	MID SUSS
	Pegist		SEP 0 8	2004	. K	Breek)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Year **Physician** Sept. 4, Irene Odessa Sullivan 8:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Nursing Home Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 29, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country)
 Maryland **Funeral** 1 ☐ M 2 😿 F 213-26-4647 93 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, I's Medical Examiner must be notified at 10d, Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 ☑ No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 S. Rolling Road 21228 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "rany injury or other traumatic evant, If any injury or other traumatic evant, If a Med Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell Allen Carolyn L. Krill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1aw 1608 \ S. \ Rolling \ Rd. \ Baltimore, MD. 21$ 19a. Informant's Name/Relationship (Type, Print) Kate Dawson, granddaughter-in-law Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bayview Crematory 9-7-04 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate of Vital 1 Yes 2 🗆 No 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH OU JAW, STREET, SATTIMONE MOZIZOI Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nó) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mary Sweigart /Medical August 30, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Yrs. 82 Director 21**5-18-**2447 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6955 Fair Lane 21774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3₺ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Switchboard Tech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: It item 27 is marked o Claude Wolfe Essie Sours 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Sweigart (Grandson) 6955 Fair Lane New Market, Maryland 21774 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Crestlawn Memorial Gardens 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: It any injury or once. 4 Donation 5 Other (Specify) 9-3-2004 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical attending ( IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be MYOCARDIAL 1 Yes 2 No 3 Probably 4 → onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-Natural 5 Pending after death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 57796 31, 200 4 coma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Seventh Street Frederick, Maryland 21701

400 W.

Registrar's Signature

Dr. Lalit Verma

			1 - For State Ragistrar	State of Man		artmen rtificate				-	giene	01.	22362
	Physic	ian	1. Decedent's Name (First, Middle, Last)	*h						2. Date of De Month	Day	Year	3. Time of Death
1	/Medi Exami		Lawrence Ar  4a. Facility Name (If not institution, give st		<u>S</u>	4b. City,	Town, or	Location of		Septemb		2004 by of Death	7:30A M
			1112 Baker Avenue			_	timo					timor	2
	Funeral Director		5. Social Security Number 6. Sex 218-26-9080	7. Age (li M 2□F 79	n yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bin (Month, Da May 30	v. Year)	9. Birthp Cour	lace (State or Foreign htry) Vland
•	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ncation					1723		
	the Marylar 28e-f show	ctor	Maryland Baltimore		Baltimor							,	0d. Inside City Limits 1 ☐ Yes 2 No
	with the	Directo	10e. Street and Number 1112 Baker Avenue			10f. Zip					10g. Citizen of		•
	death ms 23	Funeral		2. Was Decedent Eve	r in U.S. 13. 1		207 ent of His	spanic Orio	pin? (Spe	crfy Yes or No- Rican, etc.)	United	State	
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Maryland	should be filed with nd Mental Hygiene. marked other ther imatic event, the M	Be	17. Father's Name (First, Middle, Last) Arthur Snoots							(First, Middle,	Maiden Sumar		B G BICCUI
aryli	s 1 and 2 should f Health and Mer item 27 is marks other treumatic	ဥ	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	a Address	(Street a			oulter	r, City or Town,	State 7in	Codel
, M	1 and 2 s Health ar iem 27 is	10	Carrie Browning - 1	Daughter	1114	Baker	Ave				Maryla		
nore	eges 1 au int of Hea t: If Item y or other		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Ref	noval from State	Ob. Place of Dispos cemetery, cren	sition (Name natory or oth	e of her place	)	Da	ate	20c. Location -	City or To	vn, State
Baltimore,	permit. Peges Department of I Importent: If Ite any injury or or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		Lakeview				9/06		Sykesvi nsville		Maryland
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S. Carrie	Physician		23 Part1. En er the disease, or complica hock. Peart failure. List only one Immediate Cause (Final	itions that calk ed the cause of the cause.	$\circ$ . $/$			such as c	ardiac or	(3	~		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a co		gen	1C	LV	19	Cour	цопа	- 4	monks
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1	nd ransit	Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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	as as	Aedical	d										
Вох	res that the death certification of the detached for use as	Physician/Me	in the past 12 months?	If yes, outcome of pr	Fetal death 3 🗌	Ectopic preg					23d. Dat	e of deliver	
P.O.	0 0 0	hysic	1 Yes 2 No 9 Unknown	4□Pregnant at time 9□Unknown	of death 5 📙	Other (spec	cify)				Mo	nitri L	Day Year
ds, F	The law requires that the ste has been signed by thi page 2 should be detache	þ	Part II. Other significant conditions contri	buting to death but no	t resulting in the un	derlying cau	ısə givən	in Part I.					cause of death?
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Division	Dr.:	icatic	2 Accident investigation			М	1 □ Ye	s 2 🗆 No					
ò	ef or Attendates after death	Certification;	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, streen necify)	et, factory, o	office		28	f. Location (Str City or Town	eet and Numbe State)	er or Rural F	Route Number,
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	ro the vithin 2 Fo the complet		one) 29b. Signature and title of gertifier	and manner stated.									
			> Robert C	Mull	ES MI	2	D	252	2>4	-	SEP KUL	ec 3	2004
	OKINA		30. Name and address of person who comp	eleted cause of dead	(Item 23a) (Type, P	A Roll	in	Read	0	ruite	Color	silla	e Namy but
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				State of Maryland / Department	t of Health and e of Death	d Mental Hyg	_	20261
_		Physici /Medic		1. Decedent's Name (First, Middle, Last)  Cecelia Louise Slone		2. Date of Deat Month Septemb	h Day Yea	
		Examir			Town, or Location of De LTIMORE	eath	4c. County of De	
		Funeral Director		5. Social Security Number $\begin{array}{ccc} 6.  \text{Sex} & 7.  \text{Age (In yrs. last birthday)} \\ 212-44-8060 & 1  \square  \text{M} & 2  \text{$\mathbb{X}^{F}$} & 76 & \text{Yrs.} \\ \end{array} \begin{array}{c} \text{If Under Months} \\ \text{Wonths} \\ \end{array}$		Ars. 8. Date of Birth (Month Day)	928 M	irthplace (State or Foreign aryland
		Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or Location  Maryland Howard Elkridge				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
		h with the 23a or 28a 51 be toti	al Director	10e. Street and Number 10f. Zip	Code 21075	11	0g. Citizen of What o	Country?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 te marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, I'm Medical Enaminer must be tradified at once.	Completed by Funeral	1  Never Married 2 Married 1  Yes 2 No If Yes, Give No 1 Yes 2	ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, W! Specify:	
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	d 212	filed with Hygiene other tha		Elementary/Secondary (0-12)  11  College (1-4or 5+)  Homemaker  17. Father's Name (First, Middle, Last)	18. Mother's I	Name (First, Middle, M	Ownhome	
	ylan	nould be d Mental narked natic ev	To Be	Frank Schneider	Cath	erine Krau	se	
25	, Mai	and 2 shealth and not 27 le n		Emmett Slone, Jr. / Son 8049 Fair	(Street and Number or Breeze Dri			
79	more	Pages 1 ent of He nt: If iter ry or oth	1.0	20a. Method of Disposition  1			Marriotts	r Town, State Ville, Md.
05/20/28	Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee 22. Name and	d Address of Facility	Hubbard F	uneral Ho	me, Inc.
000°.		Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CELEBROVASCULAR Due to (or as a consequence of):		liac or respiratory arre	e, Maryia st,	Approximate Interval Between Onset and Death
ELIA	8760,	te be executed ysician and e burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
seco	O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be within 24 hours after death.  To the Funeret Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown   1   Unknown   2   Fetal death   3   Ectopic present   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (special content   5   Other (			23d. Date of de	olivery Day Year
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200	Vital Records,	n: The law re ficate has bee or, page 2 sho	e Completed	25. Was case referred to medical			ed? prior to death?	utopsy findings available completion of cause of
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		To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c.	P16693		d. Date signed (Mon	01-2004
		4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	171.0	O CATON	J AUEN	1529
		Sta 'Registra		1. Date filed (Month, Day, Year)  SEP 0 8 2004  SEP 18 2004	,	110110000	111111111111111111111111111111111111111	- I dente

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** PM Delores Justina Robinson Seymour 9 2004 6 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata Center LaPlata Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-12-1461 Director 89 9/21/1914 Maryland Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Worcester Director Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or itema 23a or the Medical Examiner must be: 10339 Keyser Point Road 21842 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 other then College (1-4or 5+) Seamstress Tailor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H tant: if item 27 is marked out jury or other traumatic even Robert Stewart Robinson Wilhemina Justina Rauck 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Frain / Daughter 20 Jonathans Court, Hunt Valley, Maryland 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State important: i any injury o once. * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/7/2004 Baltimore, Maryland 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one pluse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit KUTWIN Physician/Medicai the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a id be detached f o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 certificate 1 ☐ Yes Division of Vital or Attending Physician: filled in by the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated 29b. Signare and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) (Type, Print) and address of AND VRY. NEW & 0 8 2004 31. Date tiled (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

				aryland / D	epartme	ent of Health and M	Mental Hyg	giene	
			1 - State Registrar	(	Certifica	ate of Death	F	Reg. No. 1	28366
	Physici	an	Decedent's Name (First, Middle, Last)  Lillian	B. Stan	nner		2. Date of Dea	ath	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	D. Stan		ity. Jawn. or Location of Death	09	4c. County of	7 7.36A W
	Examir	ier	FRANKLIN SCHAPE 1.	Lacaita	1	1) - 1	2	Rali	L M a A C
:	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs: last birth		der 1 Year If Under 24 Hrs.	8. Date of Birtl (Month, Day		Birthplace (State or Foreign
	Director		217-38-9387 1□M ¾□F	63 Y	rs. Month	ns Days Hours Min.	(Month, Day Oct 29,	v. Year) 1940	Country) Maryland
	D .		Usual Residence of Decedent				1		
	nylar show	_	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	n the Maryland r 28a-f show	cto	Maryland N/A			Baltimore			1 Yes 2 No
	ith th	Dire	10e. Street and Number		10f.	Zip Code		10g. Citizen of Wha	
4	ath w	rai	1820 Spencer Street # 219			21230		L	J.S.A.
A	after dea	nue	11. Marital Status 12. Was Decedent E Armed Forces?		13. Was De If Yes, s	cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
. /	rs aft	oy F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 反 N If Yes, Give Year or Dates:	.0	1 🗆 Yes	2 № No Specify:		Specify:	Black
,///	within 72 hours after death with the Maryland ene. Than "retural", or flems 23a or 28a-f show the Maryland at the Maryland at the Maryland at the Maryland at the Maryland at the Maryland at the Maryland at the Maryland at	Completed by Funeral Director	15. Decedent's Education	16a. [	Decedent's U	sual Occupation		16b. Kind of Busin	ness/Industry
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7		E O	12	*)		Homemaker			Home
Rand	be filed that Hygie of other is	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Sumame)	
	should be nd Mental marked o	To [	John Boone				Eth	nel Boone	
\$ 50 E	and and series	1	19a. Informant's Name/Relationship (Type, Print)	19b. !		ess (Street and Number or Ru			te, Zip Code)
42	s 1 and (f Health item 27 other tr		Jay Ball	001 01		ivision Street Baltimo			
Z 2	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of E cemetery,	Disposition (f	r other place)	Date	20c. Location - Cit	
A:	t. Partmentant:		`4 □Donation 5 □ Other (Specify)	Garrison	_	eterans Cemetery	09/09/04	Owings IV	lills , Maryland
TA A	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee			and Address of Facility Estep Brothers Fune	ral Home P.	Α.	
(/)	20240		23a. Part1 Enter the disease, or complications that clused	the death Davi		1300 Eutaw Place B	altimore, M[	D 21217	
			shock, or heart failure. List only one cause on each lin	ine death. Do no	or enter the tr			rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	NONA	RY	SARC	old		40 VEARS
	Examiner		Due to (or as a	a consequence of	i):				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enser Underlying Cause (Disease or injury	a consequence of	f):				
	uted	Examiner	cause (Disease or injury that initiated events						
	exec an an	Еха		a consequence of	f):				
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			IS SERVALE.						
Box	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		3 ⊟Ectopia	pregnancy		23d. Date of	,
	the at	sici	1 Yes 2 No 4 Pregnant at		5 Other			Month	Day Year
0	at the ded by the etached	Physician/M	9 Unknown				1		
<u>v</u>	ries that	by	Part II. Other significant conditions contributing to death but	it not resulting in t	the underlying	g cause given in Part I.			te to the cause of death?
Becords	w requir been si should	Completed	5 - 5 - 0 /			0			Probably 4 Unknown
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	icien: The certificate harector, page		UBS + Ructive	AIRL	LAU	DISEASE		2XNo 1 🗆	Yes 2□ No
× E	sicien: certific irector,	o Be	25. Was case referred to medical examiner?  1 Yes 22 No Hospital: Inpatie			26. Place of Dear			
Ť	Phys r this aral di	υ: To	27. Manner of Death  1 Natural  5 T Pending  (Month, Day			DOA 4 Indising no		ence 6 Other (	Specify)
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Division	l or Attendi after death. Director: A I in by the fu	ifice	3 Suicide 6 Could not be	ury - At home, farn	n, street, fact	ory, office			r Rural Route Number,
į	al or a safter al Dire	Certification:	4 Homicide determined building, etc.	: (Specity)			City or Town	n, State)	
	Hospital or Attending Physicien: The law requires that the death certified to the death certified the death certificate has been signed by the attending telly filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	of my knowledge,	death occurre	ed at the time, date and place,	and due to the c	ause(s) and manne	er as stated.
	To the Hospital or virthin 24 hours after To the Funeral Direction completely filled in b	Medical	one) and manner sta	ted.	or investigati	on, in my opinion, death occur	red at the time, d	late and place, and	due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signatule and title of certifier		2	29c. License number	2	9d. Date signed (M	fonth, Day, Year)
			1/x 1/www	M.1.	0.	NORY	11	U7- U	2.04
	//		30. Name and address of person who completed cause of de					> ,	Nah . a -
			31. Date fled (Month, Day Year) 32 Projetra	4000 F	- TANK	clin Square	Unive P	ALtikor	e 11 21257
	Sta Registi		31. Date filed (Month, Day, Year) 32. Fegistra SEP 0 8 2004	w B	Spark		-E		200

		For State Registrar	State of Mai	ryland	-	artmen rtificat			ind Me		giene	04	2836
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Clarer	nce	Smitl	า				2. Date of Dea Month	ug 23, 206	)4 ^{Year}	3. Time of Deat 10:45 Pm.
Examin		4a. Facility Name (If not institution, give s University Of	street and number) Maryland Medi	cal Sys	tem	4b. City,	Town, or	Location o	Death Baltimo	ore	4c. Coun	ty of Death	
Funeral Director		219-22-8558	7. Age	(In yrs. las 75	t birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	B. Date of Birt (Month, Day Apr 5,	, 1929	9. Birth Co.	place (State or For intry) Viaryland
show in the same	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City,	Town or Lo	cation	Ва	ltimore					10d. Inside City Li X 1 Yes 2
a or 28a-	Director	10e. Street and Number 751 W. Saratoga Street				10f. Zip	Code	2120	)1		10g. Citizen of	What Cou	
"naturet", or iteme 23a or 28a-f show clical Extraliner mant be notified at	by Funeral		12. Was Decedent Ev Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates:		В	Was Deced f Yes, spec	offy Cubar	spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ack, White	ican Indian, , etc. Black
r than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			(Give	dent's Usua kind of wo DO NOT us	rk done d se retired)	uring most		9	16b. Kind of I	Business/l Private	-
na Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last) Irvin M. S	Smith Sr					18. Mothe	r's Name (		Maiden Suma ola Smith		
h and 7 is m traum		19a. Informant's Name/Relationship (Ty) Denise Cooper	рө, Print)		19b. Mailir 75	ng Address 54 E. 36	(Street a 5 th Str	eet Ba	r or Rural Itimore,	Route Numbe Maryland	r, City or Town I 21218	n, State, Z	ip Code)
ite		20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	cen	netery, crei	sition (Nar. natory or o rest Ve	ther place		ery 0	8/31/04	20c. Location Owing	-	own, State , Maryland
Department Important: the any injury of ance.		21. Signatur I Fun I Service Licens	all all		22	2. Name an Es	ad Address Step Br 300 Eu	s of Facility others taw Pla	Funera Sce Bal	I Home P. timore, M	.A. D 21217		
bhysician and standing of the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the Unit at initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a d.	conseque	nce of):								Onset and Deal
by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal d	eath 3[	Ectopic pr						ate of deliver	rery Day Year
signed I be de	b	Part II. Other significant conditions con	ntributing to death but	not result	ing in the u	nderlying c	ause give	n in Part I.		23e. Did to		atribute to 3 ☐ Pro	the cause of deatl bably 4 □Unkr
cate has been , page 2 shoule	Completed									24a. Was autop perfor 1 Yes	an 24b. sy med? 2 No	Were aut prior to co death? 1 🗌 Yes	opsy findings ava ompletion of caus 2 \( \text{No} \)
death. <b>ctor:</b> After this certificate y the funeral director, pag	25. Was case referred to medical examiner?  1   Yes   2   No									ify)			
	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hom (Specify)	e, farm, sti	eet, factory	y, office		28	Bf. Location (S City or Tow	itreet and Num n, State)	ber or Rui	al Route Number,
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./	Ž	29b. Signature and title of certifier	Z pp	)			License	590	76	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	29d. Date sign	37	Day, Year)
h		30. Name a for dre of per on who co	impleted cause of dea	ath (Item 2	!За) (Туре,	Print)					Baltie		

			For State Registrar	State of Ma	aryland / Depa	artment of H	lealth and M	ental Hygid	-	28368
	Dhunini	-	1. Decedent's Name (First, Middi	e, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		Denise	G.		Stanley		8 3]		6;30a M
	Examir		4a. Facility Name (If not institution	n, give street and number)			Location of Death		4c. County of De	ath
			Joseph Ritch	ie Hospice		Baltin	nore		NÄ	
	Funeral Director		5. Social Security Number 219–62–1155	6. Sex 7. Ag 1 ★ 2 ☐ F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 3–17–62	ear) (	irthplace (State or Foreign Country)
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl Fsho	ō	Md.	NÄ	Balt	imore				1½ Yes 2 □ No
	the N	Funeral Director	10e. Street and Number	IVI	Dari	10f. Zip Code		100	Cisiona of latters of	
	with	۵	803 N. Bradfo	rd C+		2120	5	100	g. Citizen of What ( USA	Sountry ?
	eath	era	11. Marital Status	12. Was Decedent	Ever in IIS 13			acifu Vac or No	14. Race - An	anican Indian
	ter d	ڃ	1 TNever Married 2 Mar	Armed Forces?		Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
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21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Medical Exertical for routilied at	Completed		t's Education	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Busines	
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<u>la</u> l	Menta Merita arked	ToE	Norman	Stan	ley		Hattie		Day	
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other then or other treumatic event, I'm M.		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number, C	City or Town, State,	Zip Code)
	1 and 2 Health tem 27 I	1 3	Briannetta Eg	gleston Daux	hter 812	N. Mader:	ia St., B	altimore,	Md. 21	205
Baltimore,	es 1 a of Hea fitern rothe	1 "	20a. Method of Disposition		20b. Place of Dispo				c. Location - City of	r Town, State
Ĕ	permit. Pages 'Department of H Important: If ite any injury or of		1 ☐ Burial 2 M Cremation  1 ☐ Donation 5 ☐ Other (S		Greenmou	ınt Cem.	9-7-	04 F	Baltimore	, Md.
alt	permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee		2. Name and Addres			more, Md	
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	Physician /Medical Examiner	<u>.</u>	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a	ALDS a consequence of):	er the mode of dyin	g, such as cardiac c	or respiratory arrest	,	Approximate Interval Between Onset and Death
68760,	ficate be executed g physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	a consequence of):					
P.O. Box	The law requires that the death certific: ate has been signed by the attending pl page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	res that igned b be deta	by Pr	Part II. Other significant condition	ons contributing to death be	ut not resulting in the u	nderlying cause give	on in Part I.	23e. Did tobac	co use contribute	to the cause of death?
Records,	w requires been sign should be	eted b	renal Fair	one po	lysobstan	re rse	<del>/</del>	1 🗆 Yes	2 No 3 F	robably 4 Unknown
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Vital	Physician: r this certific ral director,	Be c	25. Was case referred to medica examiner?	Hospital:		othe Othe	26. Place of Death		1	home
o	ting After funer	ition: To	1 Yes 2 No  27. Manner of Death  Autural 5 Pendir 2 Accident investi		y 28b. Time of	28c. Injury Work	at at	me 5 Residence 28d. Describe how		ecify) TOPTO
Division	i Cit	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, str.: (Specify)	eet, factory, office	4	28f. Location (Stree City or Town, S	et and Number or F State)	lural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifyir  Check only one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, a ninion, death occurre	and due to the caus ed at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifie	& When	mall.	29c. License	number	29d.	Date signed (Mon	th, Day, Year)
	m	ŀ	30. Name and address of person	who completed cause of de	eath (Item 23a) (Type,	Print)	1105	-	70/10/	
			1000 E.	Eager S	rect.	Battma	re Mo	ZIZOZ		
	Sta Registr		31. Date filed (Month, Dag Val)	0 8 2004 ^{2. Regist}	r's Signature	fresh				

				Please 7	Type or Pri				. Ensure A			Legible.	
			for State Registrar		Otate of ivi	ar y tarr		rtificate of			Reg. No.	2001.	20200
	Physicia	an.	1. Decedent's Name	e (First, Middle, Las	t)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	4a Engility Namo //		anne	K.	Smi	T	or Location of Death	09	00	County of Dea	
	Examin	er		f not institution, give		, Noize		RAITIM	Jan Location of Death	1	46.	County or Dea	ith
15	Funeral		5. Social Security N	lumber 6. Se	7. A		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v, Year)	1 0	rthplace (State or Foreign
U.	Director		102-30-54 Usual Residence of	64	□M 2 <b>⊠</b> F	67	Yrs.	,		Octobe	r 11	, 1936	Illinois
	yland how		10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Ba-1 s	Director	MD	Howard	i		E1	licott C	ity				1 ☐ Yes 2 🔀 No
	with ti	Dir	10e. Street and Nur		n 1			10f. Zip Code	210/2		10g. Citi	zen of What C	
	death	Funerai	11. Marital Status	North Rids	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of H	21043 Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	)-	U.S.A.	erican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to the fluid and Mental Hygiene.  If tiem 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, Ite Marcical Examiner must be notified at	by Fu	1 ☐ Never Marri 3 ☐ Widowed	ied 2 ☐ Married	1 ☐ Yes 2 ₹ If Yes, Give Year or Dates:			1 ☐ Yes 2 No		J rican, etc.)		Black, Wh	ne, ecc. Thite
Š	2 hou laturs	ted		15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Ki	nd of Busines	s/Industry
Maryland 21215-0036	Aithin 7 ne. hen "r	Completed	Elementary/Seco		College (1-4or		life.	DO NOT use retire	d)	King			
D	filed w Hygiel ther th	S	17. Father's Name	(First, Middle, Last)	4 year	8	EUl	LOI PIOO	18. Mother's Nam	ne (First, Middle	, Maiden	Sumame)	
<u>la</u>	should be nd Mental marked o	To Be		nknown		John	son		Laura		Bar	nes	
lary	2 shou and N Is mai	5		ame/Relationship (T					and Number or Ru				
e, S	1 and Health Sm 27 ther tr		Mrs. Allo	ce Watkins	<del></del>	20b. P	16	Earlton ( sition (Name of	Court Re	lsterst		MD ZII	
altimore,	permit. Pages 1 an Department of Heal Importent; If item 2 any injury or other once.		1 🗆 Burial 2	Cremation 3 5 Other (Specify		, a	emetery, cre	matory or other pla Cremation	сө)			stead,	
<u>=</u>	permit. Pag Department Importent; I any injury o once.	i		heral Service Licen.		11			ess of Facility118				
<u> </u>	82 = 8			eglo	Mon	Y			ral Home			wn, MD	21136
Ų,			shock, or hea	the disease, or comp art failure. List only of (Final	plications that cause	ine.	1. Do not en	ter the mode of dyll	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical	9 1	disease or condition resulting in death)		a Due to ( r as	s a consequ	uence of):	ailung	du	12			
	Examiner		Sequentially list co	anditions.	b		mo	nia					
	ted sit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate	Due to (or a	a consequ	ence of):						
,	be executed sician and burial-transit		that initiated events resulting in death)	Last	Due to (or as	s a consequ	uence of):						
8760	death certificate be executed e attending physician and nd for use as the burial-transit	by Physician/Medicai			d		<del>-</del>						
89 X	leath certificate b attending physic	/Мес	IF FEMALE:		23c. If yes, outcome	e of pregna	ncy					3d. Date of de	aliven
Box	death e atter id for u	iclar	23b. Was deceden in the past 12 1 Yes 2	months?	1⊟Live birth 4⊟Pregnant a	2 Fetal	death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			Month	Day Year
J.	t the by th ache	Phys	9 🗆 Unknown	<u> </u>	9□ Unknown		ht			an- Dida			as the server of death?
ds,	signed d be det		Part II. Other signif	ficant conditions of	ontributing to death	out not rest	ulling in the t	inderlying cause giv	ven in Paπ I.		Yes 2[		to the cause of death?
COL	w require been sign should b	iete	COPI	D						24a. Was	an	24b. Were a	utopsy findings available
Vital Records,	The lay	Completed	Diven	monia						autoj perfo	osy ormed? 2.2 No	prior to death?	completion of cause of
/ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case refer examiner?		11				26. Place of Dea	th (Check only o			
ō	Physi r this c ral dire	- To	1 Tes 2 2	INO	Hospital: Inpat		ER/Outpatie	1 0 001		ome 5 Resi			ecify)
0	nding ath. r: Afte e fune	ation	1 Natural 2 Accident	5 Pending investigation	28a. Date of Inj (Month, D	ay Year)	Injury	Wo	rk?  Yes 2□No		,		
Division of	To the Hospitel or Attending Physicien: The within 24 burs after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be determined 28f. Local Could not be						28f. Location ( City or To	Street and wn, State	d Number or F	lural Route Number,		
	pspitel hours a ineral I		29a. Certifier	Certifying Ph	ysician; To the bes	t of my kno	wledge, deat	h occurred at the ti	me, date and place	, and due to the	cause(s)	and manner a	s stated.
	the Ho iin 24 the Fu	Medical	(Check only one)		and manner s	of examina tated.	tion and/or in			rred at the time,			
i	To To Con	~	29b. Signature and	title of certifier	211.0-	0.	-	29c. Licens				-	th, Day, Year)
	= /		30. Name and addr	ress of person who	completed cause of		23a) (Type,	Print)	61529		(/	4/02/ Mo.25	
	Ψ		M	rex Go	PRIEN		SIM	1 1 -	im o	£ 180	NI	mo, 25	
	Sta Registr		31. Date filed (Mon	nth, Day, Year) SFP 0 8 20	R	trar's Signa	ture	and a					

04-0562			Type or Print in E	Black In	delible lnk.	Ensure A	All Copie	s Are L	Legible.		
crn		1_ For State	State of Marylan				Mental H	ygiene	001	2784, grbg, rdg	
		Registrar  1. Decedent's Name (First, Middle, Las	(t)	Cei	rtificate of	Death	2. Date of D	Reg. No.	004	3. Time o	7 Death
Physic		Bortha &	mith				Month Augus	Day	Year 2004		P M
/Med Exami		4a. Facility Name (If not institution, give	street and number)			r Location of Deat			County of Deat	h	
		Sinai Hospital  5. Social Security Number 6. S	9x 7. Age (In yrs.	la et hirthday)	Balti If Under 1 Year	MOTE  If Under 24 Hrs	8. Date of B	ligh	N _j		ar Foreign
Funera Director			DM 224 94	Yrs.	Months Days	Hours Min.		2, 191	O Per	hplace (State untry)	Jania
filed within 72 hours after death with the Maryland Hygiene. Hygiene then "naturel", or items 23a or 28a-f show ent, the Medical Evantia or must be rediffed at	ctor	Maryland 10b. County	10c. Cit	y, Town or Lo	MORE						City Limits
with the	Funeral Director	10e. Street and Number	llah St		10f. Zip Code	517		10g. Citiz	zen of What Co	untry?	
death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	lispa <i>n</i> ic Origin? (S an Mexican Puer	Specify Yes or No Rican etc.)	No- 1	14. Race - Ame Black, White		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Exprired Intelligible Intelligible.	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		1□Yes 2▼No	Specify:			Specify: $B$	ack	
within 72 then.	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kin	nd of Business/	Industry	
filed v I Hygie other i	Be Co	17. Father's Name (First, Middle, Last)			omes	18. Mother's Na	me (First, Midd	le, Maiden	Sumame)	16	
should be nd Mental marked d	Tof	Benjamin	Cole			Bert	ha	Col	e		
d 2 sh d 2 sh th and th and th and treum		19a. Informa s Name/Relationship (	Type, Print) (July 1917er)	19b. Maili	ng Address (Street	and Number or R	ural Route Num	ber, City or	Town, State, 2	Tip Code)	17
item 27		20a. Method of Disposition	1 ,	Place of Dispo	osition (Name of matory or other plac	(9)	Date	20c. Loc	cation - City or	Town, State	/
Pages ment of I		1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	zenMoi	LA	dory 417	1/2004	Ba	Ito. N	1d.	
permit. Departi		21. Signature of Funeral Service Licer	SPO PILA	رُّ ا	2. Name and Addre	ss of cility	Fungra	al H	ome	> i/	
		23a. Parti Enter the disease, or com	plications that caused the deat	h. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory	arrest,	141cl. 21	Approxima Interval Be	ite
Physician	,	shock, or heart fallure. List only Immediate Cause (Final disease or condition	Atiperteris	ve A	eno clari	ti ( und	io Van Sau	len	Disea	Onset and	
/Medica Examine	_	resulting in death)	Due to (or as a conseq	uence of):							
	90	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conseq	uence of):							
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с								
		resulting in death) Last	Due to (or as a conseq	uence of):							
ficate g physi	edica	•	d								
The College, It.O. DOX 00 (00). The law requires that the death certificate be existenced by the attending physician page 2 should be detached for use as the burial	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)	y		2	3d. Date of deli Month	-	Year
that the death	Phys	9 Unknown	9□ Unknown	Mine to the	4.4.	- i- D I	On Die	14242222		M	d
w requires that s been signed to should be deta	by	Part II. Other significant conditions of	ontributing to death but not res	uiting in the u	ndenying cause giv	ren in Part I.		Yes 2	se contribute to ∃No 3 ⊟ Pro	obably 4	
w requires should	ompieted						24a. Wa		24b. Were au		
The la	omo						per	opsy formed? 2  No	prior to death?	completion of a	cause of
Physicien: r this certificated rail director,	BeC	25. Was case referred to medical examiner?	Linewitch.		0.1	26. Place of De	ath (Check only	one)	-		
Physi Physi rathis o	2:10	1 XYes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie		4   Nursing r	Home 5 ☐ Re 28d. Describe			cify)	
Attending r death. ector: After by the fune	atior	Natural 5 Pending investigation	(Month, Day Year)	I <i>n</i> jury		rk? Yes 2 □ No					
el or Atte s after de la Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location City or T	(Street and own, State)	d Number or Ru	ıral Route Nun	nber,
To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledical (		y <b>sicien</b> : To the best of my kno niner: On the basis of examina and manner stated.								s)
Toti withii Toti	Ň	29b. Signature and title of dertifier	1.0		29c. Licens				e signed (Montl		
1		1 Cont	em	- 00c\ /T		O.C.M.E.		Augu	st 31,	2004	
9		30. Name and address of person who	completed cause of death (Iter	1	11 Penn S	Street, B	altimor	e, Ma	ryland	21201	
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 0 8 2004	32. Hegistrar's Signa	ature	E .						

State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylan			Health	and M		iene eg. No. 2	101.	20271
	Physici	an	Decedent's Name (First, Middle, La SRUL	ist)			SHNAYD	ED		2. Date of Deat SEPTEM		Ž₩1.4	3. Time of Death 10:15 AM
	/Medic		4a. Facility Name (If not institution, gir	ve street and number)	)		4b. City, Town,		of Death	JEF I LITE		y of Death	10.15 AM
	Exami	ICI	MILFORD MANOR NU				BALTI					IMORE	
	Funeral Director			Sex 7. Ag 1 M 2 □ F	ge (In yrs. 89	ast birthday) Yrs.	If Under 1 Yea Months Days			8. Date of Birth JULY 28	<b>,</b> 1915	9. Birthpl Coun	ace (State or Foreign ry) UKRAINE
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	d. Inside City Limits
	Ba-fel	Funeral Director		/A				TIMORE	:				1 X Yes 2 □ No
	with the or 2	Dire	10e. Street and Number 6928 MARSUE DRI	VF #1_A			10f. Zip Code	2121	15	1	0g. Citizen of		ry? USA
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of f Yes, specify Cu			cify Yes or No-		ce - America	an Indian,
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow insal Exacultat roust be incilled at	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 If Yes, Give Year or Dates:		1	1 ⊡ Yes 2 🔯 No			rican, etc.)	Speci	ick, White, e fy:	WHITE
9	"natural",	ted b	15. Decedent's E	ducation		16a. Dece	dent's Usual Occi	pation			16b. Kind of E		
21215-0036	으로 그를 흔들	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work don DO NOT use retir	e during mos ed)	st of workin	ng	CONCT	NICT TO	NI
d 21	e filed with Il Hygiene other tha		17. Father's Name (First, Middle, Las	4		ENG	INEER	18. Moth	er's Name	(First, Middle, M	CONSTI		N
Maryland	D es	To Be	VOLK			SHNAY		į	JNKNO	ΜN			UNKNOWN
Ma	d 2 h a 7 is		19a. Informant's Name/Relationship GREGORY CHATSKY		LAW	1	ng Address ( <i>Str</i> ee BROOKMI				City or Town		
Baltimore,	ges 1 an t of Heal if itam 2 or other		20a. Method of Disposition  1 🛚 Burial 2 🗆 Cremation 3	Demoval from State	20b. P	Lace of Dispo emetery, crei	sition (Name of natory or other pl	ace)PARk	⟨ Da	ate	20c. Location	- City or To	vn, State
ţim	permit. Pages Department of important: If it important: grig any injury or o		`4 □Donation 5 □ Other (Special	fy)	OHE		OM MEMO				REISTE		
Bal	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Lice	attle			Name and Add						
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ine.	Corm	er the mode of dy				est,		Approximate Interval Between Onset and Death
	Examiner		Conventially first and distance	Due to (or as	a consequ	uerice or):		1					
	ed isit	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as	a consequ	uence of):							
ດ້	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):				_		=	
8760,	ate be hysicia the bur	licai		d									
9	eath certifica attending ph I for use as th	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	ncy					23d D	ate of delive	N
.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnan Other (specify)	cy					y Day Year
Records, P.	quires that in signed t uld be det	by	Part II. Other significant conditions	contributing to death b	out not resi	failu	nderlying cause g	iven in Part I	l.		oacco use con es 2 □ No		cause of death?
eco	e law requir has been si je 2 should	Completed	127	nerten	100	1				24a. Was ar	V	Were autop	sy findings available
al R			D	invetos						perform	ned? P No	death?	2□ No
Vital	Physician: This certifical ral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ont 2□	ER/Outpatier	it 3 DOA	ther /	~	(Check only only only only only only only only		os (Casata	
n of		H	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury			-	8d. Describe ho			
Division	eat or:	catic	2 Accident investigation 3 Suicide 6 Could not	on			M 1[	Yes 2	-	06 Lanatina (Ct			
Dİ	i te	Certification:	4 Homicide determined	building, ei	tc. (Specify	me, farm, str	eet, factory, office	)	2	8f. Location (Sti City or Town	reet and ivumi i, State)	per or Hurai	Houte Number,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Direc	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner st	of examina	wledge, deatl tion and/or in	n occurred at the vestigation, in my	time, date ar opinion, dea	nd place, a ath occurre	nd due to the ca d at the time, da	use(s) and mate and place,	anner as sta and due to	ited. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier				29c. Licer	nse number	1 /	29	9d. Date signe	ed (Month, E	Pay, Year)
			· //	1 MM			D	275	69		917	104	
	30. Name and address of person who completed cause of death (Item 23a) (T					23a) (Type,	Print)	8	Gree	ine T	nee	Rd	21208
	Sta Regist		31. Date filed (Month, Day, Year)		rar's Signa	ture	nds.						

		1 - State Registrar						Cer	tificate of	Death	1		Reg. No.	UUL	3	28312
Physici	ian	Decedent's N				1/		m-				2. Date of D Month	eath Day	, Y	'ear	3. Time of Deat
/Medi Examir		4a. Facility Nam	Willie (If not institution		street and n	M.		Та	ylor 4b. City, Town,	or Location	of Death	Augus		2004 County of		1212 p
Exami	iei		East Fe						Baltin					NA		
Funeral		5. Social Securit 247-20-		6. Sex	( M 2□F	7. Age (I	In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bi (Month, D	ay, Year)	9	Birth Cou	place (State or For ntry)
Director		Usual Residence				9	01					7–15-	-13			N.C.
and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Musical Examiner must be notified at	_	10a. State	10b. Count	•		10	0c. City, T	Town or Lo								10d. Inside City Lin
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	1- State of Maryland / Department	artment of Health and Mertificate of Death		
	Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No.)	3. Time of Death
Physician /Medical	Mary Theresa Voyce	S	ept. 4 200	
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	
	Joseph Richie House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year   If Under 24 Hrs.   R	N/A	Diah 1 - (64.4 - 5 - 1
Funeral Director	217-16-6378 1 I M 2 F 87 Yrs.	Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country) MD
, p	Usual Residence of Decedent		170371717	
Aaryla Aaryla Cshov				10d. Inside City Limits 1 ☐ Yes 2 📉 No
5 Suffer death with the Maryland are treme 23a or 28a-1 show fir at travel by mortified at Functified at Function	MD Carroll Syke:	sville 10f. Zip Code	10g. Citizen of What	Country?
23a o	6719 MacBeth Way	21784	USA	
teme et.r.a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri		merican Indian, hite, etc.
036 Urs after after after after by Fe	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2. ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🗷 No Specify:	Specify:	TTL *
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d 21	12 Ho	omemaker  18. Mother's Name (	Own H First, Middle, Maiden Sumame)	ome
Vland  vuid be ii  Mental H  arked ott	William Hyland		rine Monaghan	
ary shou and N le man		ng Address (Street and Number or Rural I		e, Zip Code)
and 2 M			sville, MD 2178	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other then "naturel", or tieme 23a or 28a-1 show any injury or other traumatic event, the Medical Examination in the modified at some.  To Be Completed by Funeral Director	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)	,	
nit. Parame ontaine linjury		Park Cem.  09/08/	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	
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	23a. Part—inter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		ncer		NIVr
Examiner	Due to (or as a consequence of):			
1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying talks. Due to (or as a consequence of):			
60, be executed iclan and burial-transit	that initiated events			
E Price B	Due to (or as a consequence of):			
	0.			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	23d. Date of Month	delivery Day Year
S s s s s	1   Yes 2   No 9   Unknown   Unknown   4   Pregnant at time of death 5	Other (specify)	- Indian	Day Teas
= = 00	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
cords w requires been sign should be			1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
I Records, The law requires cate has been sign page 2 should be			24a. Was an autopsy 24b. Were prior	autopsy findings available to completion of cause of
			performed death	i? ′es 2 □ No
of Vital Of Vital Physician: Tribis certifica	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death ( at 3 DOA Other: 4 Nursing Home		11-000
g Phy g Phy ier this neral d	27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how injury occurred	pecify) Hospite
Sior endin eath. or: Aft	2 Accident investigation	M 1 Yes 2 No		
Division of tale of the function of the function of the function of the function of the function.	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28	f. Location (Street and Number or City or Town, State)	Rural Route Number,
Division of Vital  Division of Vital  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	29a. Certifier (Check only (Check only 2   Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place, an	d due to the cause(s) and manner	as stated.
thin 24 thin 24 or the F omplete	one) and manner stated.  29b. Signature and ititle of certifier	29c. License number	29d. Date signed (Mo	
F 3 F 8	NO MD	D24170	Sentanda	er 6 2004
6	30. Name and address of person who completed gause of death (Item 23a) (Type	7	Marce MAD 21	7.01
State	31. Date filed (Month, Day, Year) SEP 0 8 2004  32 Registrar's Signature	Eulans, Dalle	FO. 2, 1010 01	1
Registrar	SEP 0 8 2004 Boun & So	silv .		

			1 - For State Registrar	State of Mary		artment of Hertificate of L		lental Hygie		28374
	Physic	ian	Decedent's Name (First, Middle, La					2. Date of Death Sept. 4	Day 2 0 0 4 Year	3. Time of Death 6:50 pwn
	/Medi	cal		E. Venemar	ın	Tu = 2		sept. 4		0.30 FWI
1	Examir	ner	4a. Facility Name (If not institution, given		•	4b. City, Town, or	ltimore		4c. County of Death  Baltimo	ore
			Heritage Nurs 5. Social Security Number 6.5		yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Funeral Director			1 □ M 2 <b>X</b> F	80 Yrs.	Months Days	Hours Min.	NOV. 177	7923 Man	yland
	ס		Usual Residence of Decedent							
	arylar show	_	10a. State 10b. County		c. City, Town or Lo	ocation owleys Q	uartere			10d. Inside City Limits 1 ☐ Yes 2 ☐ KNo
	Ne M.	ecto	MD Baltim	iore			ual cers	- 10		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tlem 27 is marked other than "natural", or items 23a or 28a-1 show important: If tlem 27 is marked other than "hatural", or items 23a or 28a-1 show important: If them 27 is marked other than "natural as required at ance.	Funeral Director	929 Bowleys Q	uaters Roa	ad	10f. Zip Code 21220		10g.	Citizen of What Cou USA	ntry?
	ms 2	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	
စ္	after or ite	Fuil	1 Never Married 2 Married	1 Yes 2 XNo		1 ☐ Yes 2 X No	Specify:	nican, etc.)	Black, White,	
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d 21	filed Hygid other ent, t	CO	17. Father's Name (First, Middle, Last				<del>_</del> _	(First, Middle, Mai	den Sumame)	· · · · · · · · · · · · · · · · · · ·
an	lid be lental ked o	To Be	Charles Wesl	ey			Frances	Leyh		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than surmatic event, the Ma	-	19a. Informant's Name/Relationship	**	19b. Maili	ng Address (Street a	nd Number or Rura	I Route Number, C	ity or Town, State, Zip	Code)
	1 and 2 Health em 27 i		Theodore Venen						d Baltimo	
Baltimore,	ges 1 t of H If ite or otl		20a. Method of Disposition 1 Burial 2 Tremation 3	70 16 0	20b. Place of Dispo cemetery, cre	matory or other place	9)		c. Location - City or To altimore	
Ë	permit. Pag Department Important: I any injury o		`4 □ Donation 5 □ Other (Speci	77		Cremato	-			
Bal	permit. Departr importa any inje		21. Signature of Funeral Service Lice	nsee	2	2. Name and Address	s of Facility Con	nellyFu	neralHom ore MD 2	eofEssex
	THE RE		23a. Part1. Enter the disease, or conshock, or heart failure. Listers		deav not en	ter the mode of dying				Approximate Interval Between
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a co	onsequence of):	X PAIN X PRE TRIPLE	LURE COMOR SUE H	A A MAN	PRX	Onset and Death
8760,	ate be executed obysician and the burial-transit	Ilcal Exa	resulting in death) Last	Due to (or as a co	insequence of):	EA		D 15EAS	Z	
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
S, D	res that th signed by t be detach	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
Records,	w require been sig should b	ted		<del> </del>				1 🗆 Yes	2 □ No 3 □ Prot	pably 4 Dunknown
ပိုင်	law ra as be 2 sh	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u> </u>	ician: The lav certificate has ector, page 2	Son						performed 1 ☐ Yes 2 ☑	death?	2 No
Vital	cian: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of	Phyaician: this certific ral director,	P	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		42 Nursing Hor		e 6 □Other (Specif	y)
u C	ding f	lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Work'	at ? ′es 2 □ No	28d. Describe how i	injury occurred	
Division	l or Attending after death. Diractor: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Diag of Inius	At home, farm, st Specify)			28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	h occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	, / -		29c. License	number	29d.	Date signed (Month,	Day, Year)
)			VALICIAROY	K STOCKE	MA	D2	7/8	8 9	15/04	
	10		30. Name and address of person who	completed cause of death	(Item 23-) (Type,	Print)	10 0		6 , .	2102
	1		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	7/1/00	(P)	UGACH	5 MD	41/2
	Sta	ate	SED 0 8 2004	32. Hegistrar's	L Chee	2	-			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mary Jo A. Weisel September 6 2004 5:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mariner Health of Catonsville Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 戸 F 43 Yrs. 216-72-3725 Director 1961 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show r then "natural", or items 23a or 28a-f sho the Medical Examinat must be notified at 1 Yes 2 No Directo <u>Maryl</u>and Columbia 5 4 1 Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5013 Cloudburst Hill 21044 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked any injury or other treumetic ev 2008. Gerald Weisel Anna Mae Burget 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Weisel - Mother 107 Kenwood Avenue Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 9/10/04 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sary L. Kaufman Funeral Home At MMP., 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 D No
9 Unknown Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page Yes 2/ Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 2 No 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Tyes investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) and address of person who c 32. Registrar's Signatu State Registrar

			For State	State of Maryland /	Department of Heal		/	211114	28376
	°0		Registrar  1. Decedent's Name (First, Middle, Las	0 1.1.10		2. Da	Reg. Note of Death		3. Time of Death
	Physici /Medio	al	Gemma	Wilson		560	rtemper	4 200	42.45 PM
	Examin	er	4a. Facility Name (If npt institution, give	tley St.	4b. City, Town, or Loca	-		c. County of Death	n
	Funeral Director		5. Social Security Number 6. Sec. 11	7. Age (In yrs. last t	birthday) If Under 1 Year If U	Index Od III-	te of Birth onth, Day, Year	-	nplace (State or Foreign untry)
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	-	, , ,		10d. Inside City Limits
	e Man ta-f sh	ctor	MD NIA	Bal	timore				1 Yes 2 No
	th with th	ai Director	109 N. Grant	ey St.	10f. Zip Code 21229		10g. C	itizen of What Co	untry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural" or Itams 23a or 28a-f show event, the Medical Examples must be notified at	by Funerai	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∄ No If Yes, Give	13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Yo exican, Puerto Rican, pecify:	etc.)	14. Race - Amer Black, White Specify: B	e, etc.
2-00	2 hour	ted b	15. Decedent's Ed	Year or Dates:	Sa. Decedent's Usual Occupation (Give kind of work done during		16b. I	Kind of Business/I	Industry
2121	d within 7 giene. ir than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Receptionist	y most of working	Me	idical t	office
Maryland 21215-0036		o Be C	17. Father's Name (First, Middle, Last)	SR.	18. I	Mother's Name (First	Middle, Maide	n Sumame)	
	nd 2 she lith and 27 is m r traum		19a. Informant's Name/Relationship (7)	A	9b. Mailing Address (Street and N 1213 Nadine D	Number or Rural Rout		or Town, State, Z	lip Code)
Baltimore,	00		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	of Disposition (Name of tery, crematory or other place)	Date	20c. l	Location - City or T	
Iţim	Pa Int:		' 4 ☐ Donation 5 ☐ Other (Specify 21. Signatur 9 Funeral Service Line	West	en Cemetery 22. Name and Address of	9-10-0	4 Ba	Itimore,	mb
Ba	permit. Departn Imports any inju		Lary A W las	1	Fory P. march F		thilton Pa	ass Balto.	mo 21289
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	Examiner		Sequentially list conditions	Due to (or as a consequence	e 01):				•
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O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	very Day Year
σ.	es that the ligned by be detact	by Ph	Part II. Other significant conditions co	ontributing to death but not resulting	; in the underlying cause given in I	Part I. 23			the cause of death?
ord	w requin been si should I							No 3□Pro	
Vital Records,		Completed					a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vita	Physician: This certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Other	Place of Death (Chec		2 CON (2	2.1
n of	ng Phy fter this meral d	<b>-</b>	27. Manner of Death 1 Section 1 5 □ Pending		Time of linjury at Work?		scribe how inju	6 □Other (Speci ury occurred	ny)
Division	Attanding r death. actor: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home.	M 1 ☐ Yes		cation (Street a	nd Number or Rur	ra I Route Number
Ο̈́	Hospital or / 4 hours after Funaral Dira tely filled in b	Certi	4 Homicide	28e. Place of Injury - At home, building, etc. (Specify)		Cit	y or Town, Stat	Θ)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier (Check only one) Certifying Phyone 2 Medical Example 1	vsicien: To the best of my knowled iner: On the basis of examination a and manner stated.	ge, death occurred at the time, da and/or investigation, in my opinion	ate and place, and du n, death occurred at th	e to the cause(s le time, date an	s) and manner as and place, and due	stated. to the cause(s)
	To tha l within 2. To tha l	Σ	29b. Signature and title of certifier		29c. License num	nber	29d. Da	ate signed (Month,	Day, Year)
	1		30 Name and address of person who of	completed cause of death (Item 23a	(Type, Print)	2921	1 4.	-8-0-	1
	9		Carole Miller	900 Couts	n ave BALT	Timorre	mp	212	29
	Sta Registr	100	31. Date filed (Ments Pay Year) 8 200	3 Registrar's Signature	Sporte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 9:45A M Walter Joseph Wessel, Sr. September 7,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Elizabeth Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M M 2□ F 213-03-5167 87 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at Director 1 ☐ Yes 21 No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 126 North Symington Ave. 23a 21228 U.S.A. Funerai death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: WW II Į. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12 Traffic Engineer Traffic Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it of Health and Mental Thomas Wesolowski Frances Budka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole M. Woodyard (Daughter) 408 Canary Court Lewes, Delaware 19958 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State The Most Holy Redeemer Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 2006. 9-9-04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave. Catonsville, Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 - No : After this certification : 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after dec. 1 Alatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Box 68760,

o

Division of Vital Records, P.

- El six 100 worrell worrer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 8 2004

31. Date filed (Month, Day, Year) SEP 0 8

YUS

32 Registrar's Signal Le

			For State	State	of Marylar	•	artment of H Hificate of I		•	giene Reg. No.	004	28378
			Registrar  1. Decedent's Name (First, Middle	e, Last)		001	imoute of i	J04111	2. Date of De			3. Time of Death
	Physici		Clara T. Wasow						Month 08	Day	Year	.,
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location of Dea			2004 County of Deat	14:10 PM
	LAGIIIII	CI	Harford Memori				Hayre (	de Grace	<u> </u>	Harford		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt		9. Birti	hplace (State or Foreign
	Director		214-12-1374	1 □ M 2 💢 F	89	Yrs.	Months Days	Hours Mir	09/26/1	1914		untry) cyland
	D .		Usual Residence of Decedent		100 0	. T						10d balds Ob Marks
	shov	_	10a. State 10b. County			ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f	Director	MD Hari	ord	B€	el Air	1.0.7.0.4			40- 014-		
	with t		10e. Street and Number				10f. Zip Code				en of What Co	untry /
	eath	eral	210A Timber 7		cedent Ever in U	15 13 1	21014 Was Decedent of Hi	ispanic Origin? /	Specify Ves or No		A. Race - Ame	ncan Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, it is M-Jical Extrainet trains be notified at	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Amed F	Forces? 2 X No Bive	'	f Yes, specify Cuba	Specify:	rto Rican, etc.)		Black, White Specify:	
21215-0036	2 hou	ed B	15. Deceden	t's Education		16a. Deced	lent's Usual Occupa	ation		16b. Kind	d of Business/	
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212	d with	E O	6	College	(1-401-5+)	Sal	es Clerk			De	epartme	nt Store
2	al Hy 1 oth	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle,	Maiden S	Surname)	
<u>ā</u>	should be ind Mental I	ဥ	Alex Karpinski					Unkno	wn			
Maryland	and and ls ma	6 7	19a. Informant's Name/Relations			19b. Mailir	g Address (Street a	and Number or F	Rural Route Numbe	er, City or	Town, State, 2	Tip Code)
	and ealth m 27	· 7	Charlotte Kapus	tensky-S		1406	S. Marsh	view Ro	ad - Stor			
o o	D 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from	n State	cemetery, cren	sition (Name of natory or other plac	·	Date		ation - City or	
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Ba	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service	assol	m							l Home, P.A. lnd 21087
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat	th. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between
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Вох	death certif e attending id for use as	Z	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pregnancy			23	d. Date of deli	very
	that the death certif ed by the attending detached for use a:	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of c		Other (specify)				Month	Day Year
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Records,	e law has b ye 2 st	Completed							24a. Was autop	sy	prior to c	topsy findings available ompletion of cause of
<u></u>	T ag	S								rmed? 2 No	death?	2 No
<u> </u>	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		<del></del>	Othe	- F	eath (Check only o			
ō		2	1 Yes 2 No 27. Manner of Death	13	Inpatient 2	ER/Outpatien 28b. Time of	1 3 DOA	4 Nursing	Home 5 Resid			eify)
O	ding h. After funer	tou	1 Natural 5 Pendir 2 Accident investi	ig (Mo	nth, Day Year)	Injury	Work	k? Yes 2 □ No		, , ,		
Division of Vital	al or Attending Ph safter death. I Director: After th d in by the funeral	fica	3 Suicide 6 Could	not be 28e. Plac			eet, factory, office				Number or Ru	ral Route Number,
á	al or	Certification;	4  Homicide	buil	ding, etc. ( <i>Speci</i> i	fy)			City or Tow	vn, State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the	ne best of my kno basis of examina inner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my or	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) ar date and p	nd manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifie				29c. License	number		29d. Date	signed (Month	, Day, Year)
	P > F 0		1 Min		MD		000	6074	8	8/2	Valu.	
	10		30. Name and address of person	who completed ca	use of death (Iter	m 23a) (Type,	Print)	1.0		210	1-1-1	
	J		M.Jokha	240	3818	AM. 5	to ni	· lis	in Sin	M	160	911
	Sta		31. Date filed (Month, Day Year)	0 8 2004	Registar's Signa	ature	,		0			
	Registi	ar	ULI	0 2004	7 Delu	J. J.	Minds.					

Registrar

State

32. Register's Signature

2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 08:30P M SEPTEMBER 03,2004 Caldwell Wolfe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2X F Director 230-34-8835 May 14, 1930 74 Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Other thanmatic evant, Ita Marylan Examinating the Indiffed at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1748 Glen Cove Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell John Edward Caldwell, Sr. Okie Alverta ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Wolfe - Son 14210 Sagewood Road, Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Øther (Specify) Bel Air Mem. Gardens 9/09/04 Bel Air, Maryland Hup ral S 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatur 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician SEPSIS /Medical Due to (or as a consequence of): Examiner ACUTE PANCREATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events CHOLELITHIASIS resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by ISCHEMIC BOWEL 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 XNo Yes Hospital or Attending Physician: ral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner: 1 Tes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl

To the Funeral Diractor:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 FRANCIS KHOO OSLER DRIVE TOWSON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 8 2004

			1 - For State Registrar	State of M	aryland /		artmen <i>rtificat</i>			and M		Reg. No.	004	283	A L
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle  4a. Facility Name (If not institution	WILSO, give street and number)	N		4b. City,		Location of		2. Date of De AMONTH	26 Day	Year 200 T ounty of Death	3. Time o	
	Funeral Director		5. Social Security Number 251–30–0858	10 SPITAL 6. Sex 1 M M 2□ F 7. Ag	e (In yrs. last l 75	oirthday) Yrs.	BA If Under Months	-11	If Under Hours		8. Date of Bin (Month, Da June 1	th Year) 9:	9. Birth Cor	nplace (State untry)	or Foreign unk
	ne Maryland 8a-f ahow ziiiied at	Director	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, To		timor								City Limits
	72 hours after death with the Maryland Insturel', or Items 23a or 28a-f ahow Jical Examiner must be motified at	Funeral Dire		1nk 12. Was Decedent Armed Forces?	,	13.	Was Deced	21	202 spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		n of What Cor USA Race - Amer Black, White	ican Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-f ahow any injury or other traumatic evant, the Maxical Examination at any injury or other traumatic evant, the Maxical Examination at ange.	Completed by F	1 Never Married 2 Marr 3 Widowed 4 Divorced  15. Deceden (Specify only highes Elementary/Secondary (0-12)	If Yes, Give Year or Dates: t's Education st grade completed)  College (1-4or s	16	a. Dece	dent's Usua kind of wor DO NOT us	Occupa	Specify: ution uring most	t of workii	ng unk		of Business/I		unk
yland 21	rould be filed w I Mental Hygie I harked othar thatic evant, th	To Be Col	unk 17. Father's Name (First, Middle,								(First, Middle,				unk
ore, Mar	es 1 and 2 sh of Health and of itam 27 is m or other traum		19a. Informant's Name/Relations  Mercy Hospit  20a. Method of Disposition 1 □ Burial 2 □ Cremation	al Center	20b. Place	of Dispo	01 St	. Pa	ul St	reet	Baltin	nore,		202	
Baltimore,	permit. Pages Department of 8 Important: If its any injury or or once.		4 □ Donation 5 ☒ Other (S)  21. Signal □ Funeral Stoce	pecify) in state	ector		Name an tate 7			oard 2120:	655 W.	Balt	imore	Street	
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8760,	icate be executed physician and physician and sthe burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	С.	a consequence										
.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deal		]Ectopic pre					23d	. Date of deliv Month	*	Year
ords, P	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant condition  A trial file  (	ons contributing to death be on Ilahop  tremia	ut not resulting	in the u	nderlying ca	use give	n in Part I.			es 2 🗆 N	contribute to to	6.	leath? <del>In</del> known
Vital Record		e Completed by	25. Was case referred to medical	Tremia					26 Place	of Dogsh	24a. Was a autop perfor 1 Yes	sy med? MS No	4b. Were auto prior to co death? 1  Yes	ppsy findings empletion of c	available ause of
of	To the Hospital or Attending Physicien: To the state death. To the Funarel Director: After this certific completely filled in by the funeral director,	ation: To B	examiner?  1 Yes ZNo  27. Manner of Death  1 Natural 5 Pendin 2 Accident investig		ry 28b.	utpatien Time of Injury		Other	r. 4□ Nur at	sing Hom	ne 5 Resid	ence 6		(y)	
Division	pital or Atte urs after de arel Directo illed in by th	Certification:	3 Suicide 6 Could r determ	ined 286. Place of Inju- building, etc	c. (Specify)						8f. Location (S City or Tow	n, State)			ber,
	To tha Hospital or within 24 hours afte To tha Funarel Director completely filled in I	Medical	29a. Certifier (Check only one)  2 Medical I	g Physician: To the best of Examiner: On the basis of and manner sta	examination a	ge, death nd/or inv	vestigation,	in my opi	nion, deat	d place, a h occurre	d at the time, d	late and pla	d manner as s ice, and due to gned (Month,	o the cause(s	)
)	8 48 4		30. Name and address * erson	eth Ms	aath (Item 23a)	) (Type,	5	54	26	3-	1	AUG	UST 2	4,20	04
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8		30 30 ar's Signature			NL	PM	KE	BACTI	MOR	E, M.	51.	205

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of I		nd Men		ene 	28382	
	Physici		Decedent's Name (First, Middle, La	•	ristina Wils	on			Date of Death Month	Day Yes		
	/Medio Examin		4a. Facility Name (If not institution, gi	re street and number)		4b. City, Town, or	r Location of	f Death	Ocpici	4c. County of D	<u> </u>	
				erick Villa Nursi				Catons		24.6.11010		
	Funeral Director			Sex 1□ M 2×F 7. Ag	e (In yrs. last birthday 84 Yrs.	Months Days	If Under 2 Hours	Min. (/	Date of Birth Month, Day, Y		Birthplace (State or Foreign Country)	
	ס		Usual Residence of Decedent					F€	ebruary 4,	1920	West Virginia	
	anylar show	ž	10a. State 10b. County		10c. City, Town or L						10d. Inside City Limits 1 ☐ Yes 2 No	
	the M 28a-f	ecto	Maryland Ba	altimore		10f. Zip Code	atonsvill	le	100	. Citizen of What		
	3a or	I D	711 Academy Road			101. 21p 000e	212	228	109		U.S.A.	
	ams 2	ner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Orig	in? (Specify	Yes or No-	14. Race - A Black, W	merican Indian,	
36	permit. Pages 1 and 2 should be itied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at one.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		.,,	Specify:	White	
Š	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16	6b. Kind of Busine	ss/Industry	
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Maryland 21215-0036	ild ba lental rked o ilc eve	To Be		G. Whetzel			re. metrici	o realito (7 m		dys Bean		
ary	2 shou and N is mai	-	19a. Informant's Name/Relationship	Type, Print)	19b. Mail	ng Address (Street a	and Number	or Rural Rou	ute Number, C	City or Town, State	e, Zip Code)	
	l and lealth im 27 har tr	1 3	Ms. Charlotte Hobse	on Daugh		4453 Manitool	k Drive L					
altimore,	nt of h		20a. Method of Disposition  1		20b. Place of Disp cemetery, cre	matory or other plac	Θ)	Date		c. Location - City		
Ħ	artme ortan injury		* 4 □ Donation 5 □ Other (Special 21. Structure   Funeral Service Lice	··)		ew Memorial . 2. Name and Addres		09/08/2	2004	Sykesv	ille, Maryland	
Ö	Der Imp		MULAULK	Chetok	293	Slack F	Funeral h	Home, P.	.A. P. Ellicott C	City, MD 210	<b>43</b>	
П			23a. Part1. Exter the disease for conshock, or heart failure. List only	plications that caused one cause on each li	the death. Do not en	ter the mode of dying	g, such as c	ardiac or res	piratory arrest	).	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		epsis					Onset and Death	
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ת ת	s that med by	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause give	en in Part I.	2	23e. Did tobac	cco use contribute	to the cause of death?	
ord	w require been sig should b		Ustegoroni						1 🗆 Yes	2 No 3	Probably 4 DUnknown	
Division of Vital Records,	e law l has b	Completed						2	24a. Was an autopsy	prior t	autopsy findings available completion of cause of	
a	n: Th fficate or, pag		25. Was case referred to medical						performed ☐ Yes 2			
$\leq$	ysicia is carti directo	o Be	examiner?  1 \( \sum \text{Yes}  2 \sum \text{No} \)	Hospital:	nt 2 ☐ ER/Outpatie	nt 3 DOA Othe		of Death (Che		e 6 Other (Sp	necify)	
<u>o</u>	or Attending Physicien: The lavatter death. Director: Atter this certificate has in by the funeral director, page 2	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o					injury occurred	Journal	
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2	al or A s after i Dirac d in by	Certification:	4 Homicide determined	building, et	ury - At home, farm, st c. (Specily)	eet, ractory, office		201. C	City or Town, S	State)	Rural Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certification after death.  To the Funaral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 XiCertifying P	rysician: To the best	of my knowledge, deat examination and/or in	h occurred at the tim	e, date and	place, and di	ue to the caus	se(s) and manner	as stated,	
	thin 24 thin 24 the F	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.	29c. License		- Occurred at		Date signed (Mo		
,	F 3 F 8		. ^ /	angue		-		1			7,2004	
	18		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) 325	H 05817	CAL.	DRIVE	SUITE	208	
	\		DR. OCHANE  31. Date filed (Month, Day, Year)	9		SU	en B	MENIE	E MD	21061		
	Sta Registra		SEP 0 8 20	04 Been	ar's Signature	ande						

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of			giene Reg. NG. (	104	28383
			1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	bath Day	Year	3. Time of Death
	Physici /Medic		ROBERT LEE A	RNOLD, Sr.				August	23,	2004	2:30p M
	Examin		4a. Fecility Name (If not institution, giv	street and number)		4b. City, Town, o	r Location of Dear	th	4c. C	ounty of Death	
			2353 Klej Grange	Road		Pocomo	ke City		Wor	cester	
	Funeral		Social Security Number 6. S		(In yrs. last birthday	Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. Birthp	lace (State or Foreign try)
	Director		213-30-3051	<b>X</b> M 2□ F	70 Yrs.	Working Days	110013	6/12/1		Mary	
	pu ,		Usual Residence of Decedent		10c. City, Town or L						Od. Inside City Limits
	aryla	<u>.</u>	10a. State 10b. County		•						1 ☐ Yes 2 🛣 No
	Ba-1	cto	MD Worceste	r	Pocomoke						
	or 2		10e. Street and Number			10f. Zip Code			10g. Citize	n of What Coun	itry?
	ath w	ra	2353 Klej Grange				1851			USA	-11.1.1
	er de	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	)~   14	. Race - Americ Black, White,	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	2	1 ☐ Yes 2🔼 No	Specify:		S,	pecify: whi	to
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow he Wadical Examiner in the benotified.		15. Decedent's E		162 Dec	edent's Usual Occup	nation		16h Kind	of Business/Inc	
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72	withi ene. ther	E	Elementary/Secondary (0-12)	College (1-4or 54		cker			Tran	sportat	ion
	filled Hyg other		17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle,			
an	ld be ental ked o	To Be	Harry Arnold				Doroth	y Knight			
Maryland	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ling Address (Street				own, State, Zip	Code)
Š	nd 2 lith a 27 is r trau		Robert Lee Arnold	Jr. (son	) 235	3 Klej Gra	ange Rd.	, Pocomo	ke Ci	ty, MD	21851
ē,	Hear Hear tem othe	1	20a. Method of Disposition	•	20b. Place of Disc	THE RESERVE AND ADDRESS.		Date		tion - City or To	
J 0	Pages nent of ent: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specific		1	y Cremato	1 .	5/04	Sali	sbury,	MD
Baltimore,	근본 현 등		21. Signature of Fureral Service Lice			22. Name and Addre					
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89	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:								
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O. E	0 0 0	sic	1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)				World	-u,
Ρ.	thet the deathed by the atte	Phy	9 Unknown				on in Book!	230 Did to	obecce use	contribute to th	e cause of death?
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ec	has b	Completed						24a. Was autor	osv	prior to con	osy findings available mpletion of cause of
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/ita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	. I can hali		101	A Line Comments	ath (Check only o	one)		1
1	S S D	၉	1 ☐ Yes 2. No	Hospital: 1   Inpatien			4 🗀 Nursing i	lome 5 Resid			)
טַ		on:	27. Manner of Death 1 Selatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe h	how injury o	ccurred	
Division of Vital Record	Attending it death. ector: After by the tune	ertification;	2 Accident investigatio				Yes 2 □No	Part III			
Z	or Attendation after deati	III.	4 Homicide determined		ry · At home, farm, s (Specify)	treet, factory, office		City or Tox		vumber or Hura	l Route Number,
	Hospitel or 24 hours afte Funeral Dir tely filled in b	O	20- 0		( t	al-					-1
	To the Hospitel or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Example 12 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example	nysician: To the best of	examination and/or i	ith occurred at the tirn nvestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	date and pl	io manner as st ace, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stat	er.	29c. Licens	se number		29d. Date of	signed (Month, I	Dav. Year)
1	To Cor	-	250. Signature and title of certifier	west			4422		<b>©</b> .	-24-	54.
									۵		•
ŀ	1/2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type		MD.	21851			
			31. Date filed (Month, Day, Year)	32. Fagistra		1		- /			
	Sta Registr		AUG 2 4	2004 Keney	r's Signature	parte					

Pahar Lusun as Jessie Ambush

		1 - For State Registrar			Department of Certificate of			Reg. No.	00001					
Physici	an	1. Decedent's Name (First, Middle, L Jessie	May	Ambu	124		2. Date of D	Death Cau Ye	ar Jime of Deat					
/Medic Examir	cal	4a. Facility Name (If not institution, g.				or Location of Death	Augus							
⊏Xamı	ler	Sinai Hospital	of Balk		Besha			4c. County of D	reatri					
Funeral Director		5. Social Security Number 6. 214 - 28 - 2402	Sex 7. Ag	ge (In yrs. last b	irthday) If Under 1 Yea Months Days		8. Date of B	lay, Year)	Birthplace (State or For					
D A		Usual Residence of Decedent  10a. State 10b. County		10c City Toy	vn or Location		J		10d Inside City Lie					
B-1 sho	tor	Md. Frede	rick		lerick				10d. Inside City Lir					
3e or 28	i Dire	10e. Street and Number 3720 BQ51	Ford Ro	ad	10f. Zip Code	703		10g. Citizen of What	Country?					
ems 2	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spo	ecify Yes or N		merican Indian,					
n / z nouis arier dean with the Marylar "naturel", or items 23e or 28a-1 show edical Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 Z No		nicali, etc.)		slack					
"natu	ieted	15. Decedent's l (Specify only highest g	ducation rade completed)	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation during most of worki	ing	16b. Kind of Busine	790 ./					
r than	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	Domestic	9 <i>a)</i>		Private	-amilies					
perint. Tages I and 2 should be filled within 72 hours after death with the maryland perints. Tages I and Mential Hygiene. Integrate of Health and Mential Hygiene. Integrate of Health and Mential Hygiene in Integrate it is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, I'm Medical Examinar must be notified at once.	To Be C	17. Father's Name (First, Middle, Las Roger Elijah	"Herbert			18. Mother's Name Jessie		e, Maiden Sumame)						
th and h		19a. Formant's Name/Relationship Sandra Mae	(Typa, Print) Harris		o. Mailing Address (Stree	nt and Number or Aura	, 4 /	ber, City or Town, State I'ms foun						
item item		20a. Method of Disposition		20b. Place o	of Disposition (Name of ary, crematory or other pla	(20)	Date	20c. Location - City	or Town, State					
tent: If					side umc Co	em. Aug.	27,2004	f Frederic	ch, Md.					
Departimon Importantimon any in		21. Signature of Funeral Service Lice	21. Signature of Funeral Service Licensee  Sunny Side UMC Cem. Aug. 27, 2004 Frederick, Md.  22. Name and address of Family neval Home											
		23a. Part1. Enter the disease or cor shock, or heart failure. List only	nplications that caused	the death. Do	111				Approximate					
hysician		Immediate Cause (Final disease or condition	a	S	eosis				Interval Between Onset and Death					
Medical xaminer		resulting in death)	Due to (or as	a consequence	of):				)					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Linease or injury)	b. — Due to (or as	a consequence	of):									
and I-transit	xaminer	that initiated events resulting in death) Last	C. Due to /or as	a consequence	of).				i i					
physician as the burial	caiE		d	a consequence	uij,									
ing phy e as th	Physician/Medical	IF FEMALE:												
attending pt for use as t	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ey .		23d. Date of o	delivery Day Year					
by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
signed I	by	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying cause gr	ven in Part I.		tobacco use contribute						
5 5	etec	Dial ales	SC 1-0100	- Uise	حريد		24a. Was	Yes 2 No 3						
been si should t	Completed	Cacanori	Artena	Niva			auto	psy prior t ormed? death						
ite has bee	O	25. Was case referred to medi examiner?	111100	io iyeli		26. Place of Death	1 Yes		es 2 4 No					
	Be	1 🗆 Van - 05045-	Hospital: 1 Impatie		Itpatient 3 DOA			idence 6 Other (S)	Decify)					
	To Be	1 Yes 2 No		Year)	njury Wo	rk? ]Yes 2∐No	.Ba. Describe	how injury occurred						
ofter this certifica	To Be	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Date)		M 1	192 5 1140								
offer this certificate has	To Be	27. Manner of Death 1 ☑Matural 5 ☐ Pending	n ne ne ne	ury - At home, fa	M 1		8f. Location ( City or To	Street and Number or when State)	Rural Route Number,					
Mer this certifica	Certification: To Be	27. Manner of Death  1	28e. Place of Injuding, etchysician: To the best	ury - At home, fa c. (Specify) of my knowledge		me data and place a	City or To	wn, State)						
	To Be	27. Manner of Death  1 Pratural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying P	28e. Place of Injuding, etc	ury - At home, fa c. (Specify) of my knowledge	arm, street, factory, office a, death occurred at the ti d/or investigation, in my of	me, date and place, a ppinion, death occurres on number	city or To	wn, State)	as stated. ue to the cause(s)					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 5 2004

Sports

32. Registrar's Signature

# DAMS, ROBERT

			Please	e Type or Print in Black In	delible Ink. Ensure A	Il Copies Ar	e Legible.	
			For	State of Maryland / Depa				
			1 - State Registrar		rtificate of Death	Reg. I	18.00 L	28385
	Physic /Medi		1. Decedent's Name (First, Middle, L Robert	Goodier Adams		2. Date of Death Amonth	19 200	3. Time of Death 7:40PM
	Examir	er	4a. Facility Name (If not institution, g Doctor's Communi	ive street and number)	4b. City, Town, or Location of Death	V	4c. County of Dea	
	Funeral			Sex 7. Age (In yrs. last birthday)	Lanham  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	
	Director		130-16-8438 Usual Residence of Decedent	11© M 2□ F 80 Yrs.	Months Days Hours Min.	(Month, Day, Yea		rthplace (State or Foreign ountry) W Jersey
	how how		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Ba-1 s	ctor	MD Prince (	Georges Bowie				1 □ Yes av No
	with the	Dire	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What C	ountry?
	eath y	erai	2706 Federal La		20715	Ur	ited St	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Medical Exam har must be invitilled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	1 Yes 2 No 8-30-43	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☑ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
2-0	72 ho natura	Completed	15. Decedent's I (Specify only highest g	ducation 16a Deced	dent's Usual Occupation kind of work done during most of work	16b.	Kind of Business	
2	rithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	ing		
	iled v dygiei ther ti		12 17. Father's Name (First, Middle, Las		stems Engineer		computer	
and	d be f antal i	o Be	John Newton Adam			e (First, Middle, Maide	in Sumame)	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic event, the Men	70	19a. Informant's Name/Relationship		Zelda B ng Address (Street and Number or Rura		or Town State	Zin Codel
	1 and 2 Health a tem 27 is		Warren C. Sylves		6 Eastern Point C			21401
Baltimore,	Pages 1 and of He		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	☐Removal from State 20b. Place of Dispo	sition (Name of natory or other place) Cremation Chtr. Aug.	Date 20c.	Location - City or	Town, State
Balt	permit. Pages Department of Important: If is any injury or o		21. Signature on Fundral Service Lice	M00982 914	Name and Address of Facility Add Bestgate Road Ar	ems Funera nnapolis,	1 & Crem	nation Care
П			23a. Part1. Enter the disease, or conshock, or heart failure. List only	riplications that caused the death. Do not entry one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Provident		Immediate Cause (Final disease or condition resulting in death)	a. Sepsis				Onset and Death
	/Medical Examiner		1	Due to (or as a consequence of):				34-0
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	a			30173
	acuted ind transit	amin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_			(	
oʻ		ш	resulting in death) Last	Due to (or as a consequence of):				
68760,	ate be nysicia he bu	cai		d				
39 )	artifice ing ph e as tl	Med	IF FEMALE:					
O. Box	it the death certificate be exc by the attending physician a tached for use as the burial:	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
S, P	s that ned b s deta	by Pr	Part II. Other significant conditions	contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	w requires been sign should be		Myloproli	ferative Disord	ler	1 ☐ Yes 💈	25 No 3 □ Pr	obably 4 Unknown
Record	The lay te has age 2	ompieted	Osler W	eber Rendu		24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of
Vital		e C	25. Was case referred to medical		26. Place of Death	1 Yes 2 ZTN	o 1 ☐ Yes	2 No
	dii ys	To B	examiner? 1 ☐ Yes 2 📶 No	Hospital: 2 ER/Outpatient	Other	ne 5 Residence	6 □Other (Sne	cifv)
ion of	Attending Ph r death. ector: After th by the funeral	ertification;	27. Manner of Death    Matural   5   Pending   2   Accident   investigation			28d. Describe how inju		
Division	or Atternation after de Directo	ertific	3 ☐ Suicide 6 ☐ Could not to determined		eet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Ru e)	Iral Route Number,

within 24 hours after death.

To the Funeral Director: After this certificate has bee completely filled in by the funeral director, page 2 sho To the Hospital or Attending Physician: The law re Medical Certification: To Be Complet

autopsy performed?	prior to completion of cause death?  1 Yes 2 No
eck only one)	

- 4	o. Flace of De	dalli IUI	leck offly one)	
her:	4 Nursing	Home	5 Residence	6 ☐Other (Specify)
ry at		28d.	Describe how inj	ury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 37934 29d. Date signed (Month, Day, Year) 8 / 20/0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500

Grenbelt 20770

State Registrar

31. Date filed (Month, Day, Year) Alle 24



		1 - State of Mai		rtment of Health and tificate of Death	Reg.	PANA 28386	
Physi		1. Decedent's Name (First, Middle, Last)  Alma L. Armstrong	3		2. Date of Death Month August 2	2ay 2004 ^{ear} 3. Time of Death 11:20a.M	
/Med Exam		4a. Facility Name (If not institution, give street and number)  Chesapeake Future Care		4b. City, Town, or Location of Dea	ith	4c. County of Death  Anne Arundel	
Funera Directo	_	289-12-6313	(In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country)  1909 Kentucky	
aryland show	10		10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
th the M or 28e-1	Olrecto	10e. Street and Number	Annapolis	10f. Zip Code		. Citizen of What Country?	
5-0036 72 hours after death with the Maryland netruel; or Items 23a or 28e-1 show disal Evalute at Loutilited at	Funeral Director	1072 Sun Valley Drive  11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ★ No.	ver in U.S. 13. V	21401 Was Decedent of Hispanic Origin? (1985, specify Cuban, Mexican, Pue	Specify Yes or No-	nited States  14. Race - American Indian, Black, White, etc.  Specify: White	
	Completed by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Decec (Give	I Yes No Specify:  dent's Usual Occupation kind of work dorne during most of w OO NOT use retired)	orking 16	Specify: White b. Kind of Business/Industry	
e filed within the hygiene.		Elementary/Secondary (0-12) College (1-4or 5+ 12)  17. Father's Name (First, Middle, Last)		omemaker  18. Mother's N	ame (First, Middle, Mai	Own Home  iden Sumame)	
	To Be	Adison Winchester	10h Mailie	Nanny	Harris	Situar Tours State Zin Code)	
		19a. Informant's Name/Relationship (Type, Print)  Jody J. Wadsworth (granddau	ighter) 1	072 Sun Valley D	rive Annap	olis, MD. 21401	
0 0		20a. Method of Disposition  1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Columbia	Hill Cemetery 2	g. 24, 004 D	c. Location - City or Town, State anville, Pennsylvani	
Baltimo	SIICE.	21. Shapper of Furieral Service Liceasee  MC  23a. Part1. Enter the disease, or complications that caused to	00982 81	4 Bestgate Rd. A	nnapolis,		
68760, flicate be executed  By physician and st the burial-transit	Examiner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	Э.	ictive fulm		Onset and Death	
BOX ( ath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Unknown   9   Unknown   9   Unknown   23c. If yes, outcome of 1   Live birth 2   4   Pregnant at t 9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year	
tuires that the densigned by the a	by	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Doobably 4 Unknown	
	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
on of ling Phy After this funeral d	To Be	27. Manns of Death 1 Vatural 5 Pending (Month, Day)		nt 3 DOA Other: Nursing	eath (Check only one) Home 5 Residence 28d. Describe how	ce 6	
Atten Atten rr deat ector; by the	Certification;	≥ □ Addition to the	iry - At home, farm, str . (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner state	examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)	
To th withir To th	Me	29b. Signature and title of gertifier	_ mc	29c. License number $05072$	5	8-23-2004	
		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print) Huy Mil	brsville	MD 21108	
	State strar	31. Date filed (Month, Day, Year) 32. Paistra	r's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 20194 10:10 PM Jeanne B. Awalt /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ellicott City Howard 3918 Chatham Road 8. Date of Birth (Month, Day, Year) Aug 25, 1927 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛣 F Massachusetts 76 Director 218 22 8210 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Mazical Examinar must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21042 3918 Chatham Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Nunley Edmond Burgess 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3918 Chatham Road Ellicott City, MD 21042 Robert Awalt/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-16-2004 Metro Crematory Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee MQ1044 Uhrs 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Breat Cancer to Liver MULUSTATIC **Physician** Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospitet or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Funerel 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to lhe cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2 August 16, 2004 W8 D38500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) stuxent PK- Columbus Mo Niewer in Id. Koutre little mo 11065 64416

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 7 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

to Specie

32. Paistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22, Month **Physician** ANN 2004 8:pM S. ARNETT August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brendale Prince Georges Home Adelphi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
May 7,1908 New York City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF 96 Yrs. 579-22-6768 Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23s or 28s-f show the Medical Exeminer must be nutified at 1⊠Yes 2 No MD Prince Georges Adelphi Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2622 Lackewanna Street 20726 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status be filed within 72 hours after di Ital Hygiene. d other than "natural", or Ite⊞ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accounting Anaylst Gov. . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is marked other t jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Hill Eva Tasker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Dyson-Granddaughter 1165 lst Place, N.W. Wash. D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition p∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem.Cem permit. Page Department of Important: If any injury or once. Aug. 27,04 Suitland, MD. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licenses 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dehydration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Dementia attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 28 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2€No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending n 24 hours after death.
In E hours after death.
Ine Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D - 30927Oki Kwon, M.D. Aug. 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oki Kwon, M.D. 10313 Georgia Ave. suite 209 Silver Spring, MD. 20902 31. Date filed (Month, Day, Year) State AUG 2 6 2004 Registrar

Amended Item 5 per F.D. 08/26/2004 Carroll County, wil Wilson R. Bounds Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 5339State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Wilson R. Bounds August 18. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3004 Uniontown Road Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5217-36-4903 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 → M 2 □ F Yrs. Director 63 <del>36 4933</del> July 10 1941 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "netural", or itams 23a or 28e-f show other traumatic event, the Mudical Examinar must be notified at MD Carroll Uniontown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 Uniontown Road 21158 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural; or Itan any injury or other traumatic event, the Medical Examples. Once. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernon Maring Bounds, Sr Lou Stem Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Bounds/wife 3004 Uniontown Road Uniontown, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State St. Pauls Cemetery `4 ☐ Donation 5 ☐ Other (Specify) 8/22/2004 Uniontown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 23a. Pan. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Westminster, MD Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ

Completed

25. Was case referred to medical 27. Manner of Death Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica within 24 hours a To the Funerel D MSL 13 Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24a. Was an

autopsy performed? 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 

24b. Were autopsy findings available prior to completion of cause of death?

3. Time of Death

9:40 P

MD

10d. Inside City Limits

21157 Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2X No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 © Other (Specify) at scene

28b. Time of 12d 64 and plesty

case

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, s reet, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Surge (talmer) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 at Unintra Asad K. trust, my land

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

examiner?

1 Natural

2 Accident 3 ☐ Suicide

4 🗌 Homicide

(Check only one)

29a. Certifier

Yes 2 No

FATAM

O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

August 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEDDORF NIKE

5 Pending

investigation 6 Could not be determined

32. Regierar's Signature

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

۲			1- State of Maryland / Department of Health and M Registrar Amend #19a, 08-20-04, PerFH Certificate of Death		giene 100 Mars 28390
	Physic		1. Decedent's Name (First, Middle, Last)  MAXINE ELIZABETH BRITTINGHAM	2. Date of Dea Month	ath 3. Time of Death Day Year
	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	AUG.	15, 2004 6:35 AM M
	±Xaiiii		Salisbury Nursing and Rehab Center Salisbur	. bM . v	Wicomico
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Director		216-18-2881 1□ M 2\(\text{\text{M}}\)F 82 Yrs. Months Days Hours Min.  Usual Residence of Decedent	8. Date of Birth (Month, Day Nov. 6,	1921 Maryland
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumatic event, the May cal Examinar must be notified at	Director	Maryland Wicomico DELMAR		1 ☐ Yes 2 🛣 No
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	Item Item	Ę.	11. Marital Status  12. Was Decedent Ever in U.S. Ammed Forces?  1 □ Never Married  12. Was Decedent of Hispanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
TTINGHAM 21215-0036	within 72 hours after ene. than "neturel", or Ite he Msylcal Examina	þ	3 Midowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:		Specify: Dlack
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BRITTINGHAM and 21215-003	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name		
	shoutd Ind Men	ပ္	Charlie Bratten Ethel I		
E E. Maryl	permit. Pages i and 2 should be filed Department of Health and Mental Hygi Importent: If item 27 is marked other any injury or other treumatic event, ■ 2008.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural		
	1 and dealth sm 27 ther tr		E. Linda McNeal - Daughter E. Linda McNell/daughter  295 First Avenue - Ponti  20a. Method of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of		
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MAXIN altimore,	nit. Parantinon ortent: injury	1	4 □ Donation 5 □ Other (Specify) Green Acres Mem. Pk 08/19.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 213		
Ba	permit. Departr Importe any inju		Litetta D. Silley JOLLEY MEMORIAL (		Road - Salisbury, MD
			23a. Part1. Soter the disease, or domplicators that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one tause on each line.	respiratory arre	21801 est, Approximate
	Physician		Immediate Cause (Final disease or condition		Interval Between Onset and Death
	/Medical		resulting in death)  Due to for as a consequence of):		weeks
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	sit ad	iner	if any, leading to infinediate cause. Enter Underlying Cause, Disease or injury		
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8760,	ate be executed hysician and the burial-transit	dicai E	Substitution of a consequence of).		/-
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	eath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
В.	death	sicia	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Other (specify)		Month Day Year
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Division of Vital Records,	90	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
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Ş	Physicien: this certificatal director, J	To Be	examiner?		
0	ding Phys h. After this funeral di		27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28		nce 6 Other (Specify)
jo	tendin leath. tor: Aft the fur	atio	1 Injury Work? 2 Accident investigation (Month, Day Year) Injury Work? M 1 Yes 2 No		
i≥i	r Atte	Certification;	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Str. City or Town,	eet and Number or Rural Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, and place, a	id due to the cai dat the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To ti withii To ti comp		29b. Signature and title of certified 29c. License number	29	d. Date signed (Month, Day, Year)
			1/1/1/hun 928388	8	116/04
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	, . vy . / -
DO			William H Robins M.D. 1346 S. Division:	St.Suit	e,Sa'isbury, Md.21804
	Star Registra	ie ar	AUG 1 9 2004 32. Registrar's Signature & Sports		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar	Otate of W	arylaria i		tificate of D		R	eg. No	28301
Physicia		Decedent's Neme (First, Middle, La Robert Russe)		ysinger	. Sr			2. Date of Dea Month August 2		8:15 AM
/Medic Examin	ai -	4a. Fecility Name (If not institution, giv			,	4b. City, Town, or l	ocation of Dea		4c. County of De	ath
LAUIIIII	ŭ.	520 Washington St	reet			Salisbur	v		Wicomi	
Funeral		<ol> <li>Social Security Number 6. S</li> </ol>	ex 7. Ag	ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B	irthplace (State or Foreig Country)
Director		218-16-8824	<b>X</b> ]M 2□F	80	Yrs.	Monato Says		March 26		aryland
		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limit
I and 2 stoud by the will the will be a stone observed the many and then 27 is marked other then "naturel", or iteme 23e or 28e-f ehow other traumatic event, the Medical Exercitrent from the notified at	ŏ									1 <b>X</b> ]Yes 2 □ N
88	ect	Maryland Wicomic  10e. Street and Number	0	Salis	bury	10f. Zip Code			l 0g. Citizen of What (	Country?
S S	늅					21804	L		USA	
10 23	Funeral Director	520 Washington St	12. Was Decedent	Ever in U.S.	13.	Was Decedent of His f Yes, specify Cuban		Specify Yes or No-		nerican Indian,
Te le	E I	1 ☐ Never Married 2 ☒ Married	Armed Forces' 1 X Yes 2 ☐ If Yes, Give	?				rto Rican, etc.)	Black, Wi	nîte, etc.
naturel', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Army		1 ☐ Yes 2 🎇 No	Specify:		Specify:	White
atur cal E	Completed by	15. Decedent's E		1	6a. Dece	ient's Usual Occupat	tion	orking	16b. Kind of Busines	s/Industry
o de la	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired)	ning most or we	, king		
Hygiene other the	mo;	11			Buil	ding Conti			Construct	ion
d other then "	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
and Mental	2	Russell V.	Bays	singer			Elizabe		Dav:	
and le ma	11	19a. Informant's Name/Relationship (	Type, Print)						r, City or Town, State	
of Health Item 27 I		Donald P. Baysin	ger (sor			and the second property of	Drive,		y, Marylan	
		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 🗋	Removal from State		of Dispo	sition (Name of natory or other place	)	Date	20c. Location - City	or Iown, State
ant: h		`4 □Donation 5 □ Other (Special	(y)	Salis	sbury	Cremator	y Augu	st 23, 20	004 Salis	bury, Maryl
Department of Important: If eny injury or once.		21. Signature of Funeral Service Lice	n CF	50		Ol Snow H	ill Roa	d, Salis	ourv, Marv	Associatio land 2180
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause	od the death. (	o not ent	er the mode of dying	, such as cardia	ac or respiratory ari	rest,	Approximate Interval Between
nysician		Immediate Cause (Final	0110 02000 011 02011	Mo To	titi	e CHRCIA	GIVOL	CHAICE	0	Onset and Death
/Medical		disease or condition resulting in death)	a	s a consequen	-	0 4/1/201				1 200.
xaminer			b							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequen	ce of):					
sician and burial-transit	Examiner	that initiated events	c							
physician and s the burial-transli	Ä	resulting in death) Last	Due to (or a	s a consequen	ce of):					
physic the b	edicai		d						<del></del>	
	Me	IF FEMALE:	23c. If yes, outcom-	e of pregnance	,				and Date of a	telène.
attending For use at	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal de at time of deat	ath 3[	Ectopic pregnancy Other (specify)			23d. Date of o Month	Day Year
by the a tached t	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregnant a 9⊟ Unknown	at time of death	1 3	1 Other (specify)				
ed by detac	P	Part II. Other significant conditions	contributing to death	but not resultin	a in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
signed be del	l by		_	TENOS	-	, ,		1 🗆 Y	es 2 40 3 🗆	Probably 4 Unkno
s peed s	Completed	Λ_		01		~		24a. Was	24h Mora	autoney findings avails
2 5	ldu		RIAL	IBRIL	44	rion		autop	sy prior to death	autopsy findings availa o completion of cause ?
								1 ☐ Yes	2 No 1 Y	es 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	c	eath (Check only o		
this ald	7	1 Yes 2 No	1 ☐ Inpat		Outpatie b. Time o	IL 3LI DOA	4   Nursing		lence 6 Other (Si	oecify)
After funer	9	1 Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	f 28c, Injury Work M 1 \(\sum \)		200. 00001100 11	ow anjury occurred	
death.	Certification:	2 Accident investigate 3 Suicide 6 Could not	De Dingo of I	niury - At home	farm st	reet, factory, office		28f. Location (S	Street and Number or	Rural Route Number.
Olrec Olrec in by	in a	4 Homicide determined	building,	etc. (Specify)	, 1011111, 31	oot, ractory, onice		City or Tow		,
within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Exa	miner: On the basis	of examination					cause(s) and manner date and place, and d	
the f	led	one)	and manner s			29c. License			29d. Date signed (Mo	
S of the second	Σ	29b. Signature and title of certifier	1.1				1576	1	b 4 - A	, Day, 1841)
		1 July	my				70	9	0/23/0	7
Q		30. Name and address of perso, who	completed cause of	death (Item 2	Ba) (Type	Print)	E De	SALIS	SURY MD	10815
_		31. Date filed (Month, Day, Year) AUG 2 3 20	32 Regis	trar's Signatur		South				

DHMH 17 Rev 1/2001

113-09-

			For State	State of I	Marylan	•			Mental Hyg	artes self	· ·	
			Registrar			Cei	rtificate o	r Death	2. Date of Dea	eg. No.	104	2 3 Time of Death
	Physici	ian	1. Decedent's Name (First, Middle, Las			ממ	ADEODD		Month AUGUST	Day	Year 2004	3. Time of Death
	/Medio		HELEN 4a. Facility Name (If not institution, give	MAY street and numb	er)	DK	ADFORD 4b. City, Town	, or Location of De		_	ounty of Death	
			JOHN B. PARSONS	HOME			SAI	LISBURY		Į Į	WICOMIC	CO
	Funeral		Social Security Number     6. S	ex 7. □M 2X F		last birthday)	If Under 1 Yea Months Day		n. (Month, Day	, Year)	Cou	place (State or Foreign intry)
ь.	Director		Usual Residence of Decedent		77	Yrs.			JAN. 8,	1927	MAF	RYLAND
land	<b>M</b> ■		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Man	9	to	MD WICOM	ICO		PITTSV	ILLE					1∭Yes 2 No
death with the Maryland	or 28	Director	10e. Street and Number				10f. Zip Code	)	1	0g. Citizer	n of What Cou	intry?
ath w	23a		34536 PITTS AVEN					21850		US		
	ltem Der D	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 \( \text{Yes} \) 2	es?	.S.   13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? I uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14.	Race - Amer Black, White	
JS aft	9 1	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Date			1□Yes 2ÅN	o Specify:		St	oecify:	WHITE
2-UUSD 72 hours after	nial Hygiene. ed other than "natural", or Items 23a or 28a-f show event, tra Medical Examinat must be notified at		15. Decedent's Ec (Specify only highest gra	lucation		16a. Dece	dent's Usual Occ	supation ne during most of w	orkina	16b. Kind	of Business/Ir	ndustry
within 7	Med -	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use reti	red)	UI AII 19			
A A	her th		10			NUR	SING AII	T	ame (First, Middle,		RSING H	IOME
	d of	Be	17. Father's Name (First, Middle, Last) LOUIS	M	TD A	DVED				Malueli Su		DD.
Should should	th and Mental 7 Is marked of traumatic eve	2	19a. Informant's Name/Relationship		PA	RKER 19b. Mailir	ng Address (Stre	EDNA et and Number or i	M Rural Route Number	City or To		RD p Code)
Nd 2			JAMES M. TYNDALL-	NEPHEW		34536	6 PITTS	AVENUE	PITTSVILL	E MD	21850	
ore,		-	20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □	Domoual from St	1 -		sition (Name of natory or other p				tion - City or T	
Saltimor	artment o ortant: If injury or a.		'4 □Donation 5 □ Other (Specify			VERSID:	E CEMETE					, MARYLAND
	Department of Himportant: If Ite any injury or of once.		21. Signature of Funeral Service Licen	S00			. Name and Add		BOUNDS FU			
	LO S & Q		22a Parti Fotor the disease or com	tery Ne	llll				SALISBU		ID 2180	4 Approximate
	7		23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	ne cause on eac	h line.					551,		Interval Between Onset and Death
	hysician Medical		disease or condition resulting in death)	a	as a conseq	uence of):	alignand	- Mela	MOMA			5 years
Ε	xaminer		Constitution for the second form	h								
TO	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):						-
ou, be executed	ohysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseq	neuce of):						
	buria	a E			us u oonsoq	401100 01).						
OX OO!	phys s the	edical		. d								
DOX ath certi	igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnar	2014		23d	I. Date of deliv	ery
deat	ne atte	sicla	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnan	t at time of d		Other (specify)				Month	Day Year
	d by the	Phy	9 Unknown  Part II. Other significant conditions c					- Dadi	22a Did tol	2000 1100	anatributa ta t	he cause of death?
ecords, P.O. Do	signed bed	by	Part II. Other significant conditions c	ontributing to deat	n but not res	aiting in the ti	nderlying cause (	given in Part I.		s 2 127	_	bably 4 Dunknown
law requires	been si	ompleted							24a. Was a			opsy findings available
	- e	dw							autops perforr	ned?	prior to co death?	impletion of cause of
	certificate rector, pag	O	25. Was case referred to medical					26. Place of D	1 ☐ Yes :		1 🗆 Yes	2 □ No
OI VILA	lis cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	t 3 DOA		Home 5 Reside		Other (Speci	ASST.
	fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	Injury <i>Day Year)</i>	28b. Time of Injury	28c. In	jury at lork?	28d. Describe ho			1111111
VISION	tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be		fatire AAA			☐ Yes 2 ☐ No	206 Leasting (Co	A	(comban on Occ	al Basila Marahan
NIV Sr. As	Direc Direc in by	Certification;	4 Homicide determined	286. Place of	etc. (Specif	ome, tarm, str	eet, factory, offic	8	City or Town	reet and N n, State)	iumber or Hur	al Route Number,
soital	nerel rilled		29a. Certifier 1 Certifying Ph	ysicien: To the be	est of my kno	wledge, death	n occurred at the	time, date and place	ce, and due to the ca	ause(s) an	d manner as s	stated.
S HO	within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	niner: On the basi and manner	s of examina	ition and/or in	vestigation, in my	opinion, death occ	curred at the time, d	ate and pla	ace, and due t	o the cause(s)
To I	To t	M	29b. Signature and title of certifier				29c. Lice	nse number			igned (Month,	
			> who will					57359	1	tugui	st 18	15 2004
$\mathcal{C}$			30. Name and audress of person who					SALISTA	IRY MD 2	18011		
	Sta	ate	DR · USHA ( 31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	iture /	1	,,,	7 197	, , , , ,		
	Device		AUG 182	ma ka	enera	27	1000	61				

		•	1 = For State Registrar	State of Marylar		artment of H			giene Reg. No.?	11. 28301.			
	1. Decedent's Name (First, Middle, Last)					,		2. Date of De	of Death 3. Time of Death				
В	Physicia /Medic		Elizaheth	E Bel	rnet			Augus	+ 19 2004 1055 M				
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	ath	4c. County	Par			
			Michorage	59, ton	و	Sa	lisbu	ing	WI	comico			
	Funeral		5. Social Security Number 6. S	ex $\bigcirc$ 7. Age (in yrs. $\square$ M 2 $\square$ F $\bigcirc$ 71	last birthday) Yrs.	Months Days	If Under 24 H Hours Mi		th IV. Year)	9. Birthplace (State or Foreign Country) DELAWARE			
	Director		222-28-4904 Usual Residence of Decedent	71	113.			3-23-1	3.32	DELAWARE			
	land ow		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits			
	Many a-f sh	to	DELAWARE SUSSEX	K F	RANKFO	RD				1 ☐ Yes 2 No			
	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show telfall Examinant to multified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of W	/hat Country?					
			140K BEAVER DAM I		1994			US					
	tens tens		11. Marital Status	12. Was Decedent Ever in L Armed Forces?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No arto Rican, etc.)	tc.) 14. Race - American Indian, Black, White, etc.					
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify.	WHITE			
21215-0036	tural	To Be Completed b	15. Decedent's Ed	Education 16a. C		dent's Usual Occupa		16b. Kind of Bu	Kind of Business/Industry				
15	nin 72 n "na Massin		(Specify only highest gra	de completed) College (1-4or 5+)	(Give	(Give kind of work done during most of work life. DO NOT use retired)							
212	filed within Hygiene. ther than "		11			OMEMAKER			NONE	NONE			
	be filed htal Hygi od other event, I		17. Father's Name (First, Middle, Last)					ame (First, Middle	, Maiden Sumam	θ)			
<u>yla</u>	s 1 and 2 should be filed within 72 hc in Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Musical		CALVIN MCGEE					E TYRE					
Maryland			19a. Informant's Name/Relationship (7	CD V VID-	1	ng Address (Street a							
			STACEY M. MCCLELI  20a. Method of Disposition	20b.	Place of Dispo	BEAVER DA		FRANKFO Date		945 City or Town, State			
20	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other plac CEMETERY		2-04		RD, DELAWARE			
Baltimore,	프트란글		*4 □Donation 5 □ Other (Specification of Specification o							KD, DEDAWAKE			
B	Depa Impo any i		1 / Solling	Mason	M T	2. Name and Addres ELSON FUN HATCHER S	ERAL SE T, FRAN	RVICES, LT KFORD, DE	ΓD. 19945				
			23a. Part1 Enler the disease, or com shock, or heart failure.	plications that caused the dea						Approximate Interval Between			
8760,	Physician /Medical Examiner  white partial-transit		Immediate Cause (Final disease or condition	. ASCVI	\					Onset and Death			
			resulting in death)	Due to (or as a consequence of):									
		_	Sequentially list conditions.	b COPD									
		lne	Sequentially list conditions, and cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):									
		Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec									
		E E		d									
9	tificate ng phys as the	edlo		0.									
Вох	aath certific attending pl for use as t	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1□Live birth 2□Fet	Ectopic pregnancy		1	23d. Date of delivery					
	death	Physician/Medical	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of a	Other (specify)			Mor	nth Day Year				
P.0	that the de led by the a detached i	Phy	9 Unknown			in Book	nae Dida		ibute to the course of death?				
	Attending Physician: The law requires sr death. •ctor: After this certificate has been sign by the funeral director, page 2 should be	þ	Part II. Other significant conditions of	ontributing to death but not re-	g to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of  1 Yes 2 No 3 Probably 4				
õ		etec				24a. Was							
Vital Records,		Completed		ormed? 24b. v	24b. Were autopsy findings available prior to completion of cause of death?								
a		e Co	25. Was case referred to medical		1 Yes	1 Yes 2 12 No 1 Yes 2 No							
		To Be	examiner?	26. Place of Death (Check only one)  Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aurising Home 5 Residence 6 Other (Specify)									
of		Certification: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	f 28c Injun			28d. Describe how injury occurred					
Ö			1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1		Yes 2□No							
Division		tiffe	3 Suicide 6 Could not be determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Q	oital or urs afte ral Dir	Medical Cer											
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in			g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the comple		29b. Signature and title of certifier	and warner states.	29c. License number			29d. Date signed (Month, Day, Year)					
	<b>- ≤ +</b> ŏ		SQR M	· D .		157	952		8/19	12004			
		1	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)			41.4	12004 ,MD 21804			
7	H.10		Babulal Das	1M-D. 101	- Mil	free ST.	450	413,5	alisbung	, MD 21804			
	Sta		31. Date filed (Month, Day, Year)	M-D 104 32. Begistrar's Sign	ature	hard.							
	Regist	ell	MUUNOZ	UUT ATALAN	Nº KI	NO COL							

			1 - For State Registrar	State of M	laryland		artmer rtificat			and M	ental Hy	giene	ՈՈԱ	28395	
н	Physic	ion	1. Decedent's Name (First, Middle, L	ast)	Q.						2. Date of De	aath	37 37	3. Time of Death	
	/Medi		JUN9.	sery		ser					Month	Day	- 2004	12:40 FM	
4	Exami		4a. Facility Name (If not institution, g	ive street and number,	)		4b. City,	Town, or	Location of	f Death		4c. (	County of Deat	h	
			Carrett Co. Men	orial Hosp	oital		0a	klan				Ga	rrett		
	Funeral					ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Apr 25	th y, Year)	9. Birti WV	nplace (State or Foreign	
	Director		234 80 2776 Usual Residence of Decedent		57	Yrs.					Apr 25	1947	WV		
	land		10a. State 10b. County		10c. City	, Town or Lo	cation					-		10d. Inside City Limits	
	Many	ō	WV Minera	1		Gard								1 Syyes 2 □ No	
	28a	Director	10e. Street and Number			Cara	10f. Zip	Code				10a Citiza	en of What Co		
	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inforenti: If time ZT is marked other then "naturel" or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examine 1, wall be neitified at once.	Ö	PO Box 105					717				USA		andy?	
		Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V			panic Orig	in? (Spec	ifv Yes or No		4. Race - Amer	ican Indian	
9	after or Ite		1 Never Married 2 X Married	Armed Forces?		1	_			Puerto P	ify Yes or No lican, etc.)		Black, White	, etc.	
ဋ	rei".	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2⊠ No	Specify:			5	Specify: Whi	te	
Maryland 21215-0036	72 h	etec	15. Decedent's I (Specify only highest g	ducation ade completed)	cation ie completed)		16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)			pation 1			6b. Kind of Business/Industry		
21	Althin of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)				naig most	OF WORKER	9				
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ang S	be fi	Be	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name	(First, Middle,	Maiden S	'umame)		
ž	J Mer narke	은	William Bolyard								Smith				
a Z	12 st h and 7 Is n traun	K =	19a. Informant's Name/Relationship									er, City or	Town, State, Zi	p Code)	
e) —	1 and Healt em 2 ther	8	Douglas M. Bird	ner	20h Pis	PO ] ace of Dispo:	Box 1		Elk G			2671			
Baltimore,	ages or o		1 Surial 2 ☐ Cremation 3 i		ce	metery, cren	natory or o	ther place,	)	Da IC 201			ation - City or T		
┋	it. Part rtmer rtent njury		`4 □Donation 5 □Other (Spec		Nai	.baugh					2004	ETK	Garden,	WV	
Bal	Depa Depa Impo any ir		21. Signature of Funeral Service Lic	nsee //	lock.				of Facility		710	Churc	h St.		
	ate be executed hysician and hysician and hysician and the burial-transit		23a. Part 1. Enter the disease, or con	.Dung	VCK						Kitzr	mille	r, MD	21538	
Hecords, P.O. Box 68760,		Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  23c. If yes, outcome of pregnancy 5 Other (specify)  contributing to death but not resulting in the underlying cause given in Part I.					23a Did to		d. Date of delive	Day Year			
	w requires been sign should be	Q									tobacco use contribute to the cause of death?  Yes 2 3 Probably 4 Unknown				
		e Completed	25. Was case referred to medical								-	med? 2.3.40	24b. Were auto prior to co- death? 1 \( \sum \text{Yes}	psy findings available mpletion of cause of	
	/sicien: s certific director,	To B	examiner?	examiner? Hospital:							Check only or	Visited in the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the Contract of the			
Division of Vita	after death. Director: After this		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			3 DOA 4 Nursing Home			me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
	spitel or Att ours after de ierel Directo filled in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	n 24 hou he Funer pletely fill	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated.								ated. the cause(s)				
	o # 5 0	Σ	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)				
			1 bear man	the yes			10033464 Eston, WN 716				8/23/04				
			30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, P	rint)								
			Eston Close	Staff franc	rc 2	-7	E54	m, W	126	716					
	Sta Registr	1.C	31. Date filed (Month, Day, Year)  AUG 2 5	32. Registra	r's Signatur	re M	00								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician August 22, 2004 5:15 P M Heffner Brown, Jr. Samuel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2032 Fairfax Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-27-1933 5, Social Security Number 7. Age (In vrs. last birthday) 6. Sex 14 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months 70 Director 217-30-5941 Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "netural", or items 23e or 28e-f ahov idical Examinar must Le notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2032 Fairfax Rd. 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Wes 2 ☐ No If Yes, Give Year or Dates: 1953–55 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "netural", or Iten ury or other traumatic event. The Medical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physicist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Heffner Brown, Sr. Mary Stockton Schley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce P. Brown/ Wife 2032 Fairfax Rd., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State Kalas Crematory 8-24-04 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Malos 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician Box 68760 Physician/Medical thet asi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ठ् Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown ۵ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 autopsy performed 2 🗆 No 1 🗌 Yes 1 ☐ Yes 2EINO 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 3□ DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who strar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State C		artment of Health and Natificate of Death	Mental Hygiei	00010	0207
	8		Decedent's Name (First, Middle, Last)	00,	Timeate of Death	2. Date of Death	the second second	. Time of Death
в	Physici	an				Month	Day Year	
	/Medic		Evelyn V. Ba 4a. Fecility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		19 2004   8 4c. County of Death	3:30 A M
	Examin	er	8309 Elko Drive		Ellicott City		Howard	
	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birtholace	(State or Foreign
	Director		163 22 4156 1□ M 213℃F	76 Yrs.	Months Days Hours Min.	June 7,	ar) Country)	vlvania
	D .		Usual Residence of Decedent			Tourse 17	LJZO   I CILIDY	
	how	_	10a. State 10b. County	10c. City, Town or Lo	ecation			Inside City Limits
	Pa-f	cto	MD Howard	Ellicott	City			1 ☐ Yes 2 X No
	iii 10	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
	ath w	ra	8309 Elko Drive		21043		United Sta	ites
	er de	Funeral	Armed Fo	orces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Ir Black, White, etc.	ndian,
36	s afte		1 Never Married 25 Married 1 Yes, Gi 3 Widowed 4 Divorced Year or D	ve	1 ☐ Yes 2X No Specify:		Specify: Title	40
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow than "natural" or items 10c notified at	Completed by	3 Wildowed 4 Univorced Year or D		dent's Usual Occupation	164	Whi	
5	in 72	let	(Specify only highest grade completed)	(Give	kind of work done during most of worl DO NOT use retired)	king 166.	. Kind of Business/Industr	ry
7	than than	шo	Elementary/Secondary (0-12) College (	1-4or5+) Wai	tress	F	Restaurant	
	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apprintury or other traumatic event, It a Medical Examination in the Invitition at annex.	To B	Leroy Rodney Albright		Mary Jan	e Smith		
ary	should North		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or Rui	ral Route Number, City	y or Town, State, Zip Coc	fe)
	alth a		Milton L. Barth/Husband	8309	Elko Drive Ellic	ott City,	MD 21043	
Je,	item item		20a. Method of Disposition	20b. Place of Dispo		-	Location - City or Town,	State
Ĕ	Page sent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ② Other (Specify) Entomb	State		1-2004 Ma	rriottsvill	e. MD
Baltimore,	partm partm porta / inju		21. Signature of Funeral Service Licensee		. Name and Address of Facility Har			
m	Depa Impo any ii		Dem Collins - With		112 Old Columbia			
			23a. Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a	aused the death. Do not ente			Apr	proximate prvat Between
-	Physician		Immediate Cause (Final disease or condition	ASTARL SW	ran cell conc	30 -110	One	set and Death
	/Medical		resulting in death)	(or as a consequence of):	Coll. Coll	CIC COIC	3	mth.
	Examiner		Sequentially list conditions b					
		ner		(or as a consequence of):				
	nd ransi	Examiner	Cause (Disease or injury that initiated events c.					
ő	e exe ian a urial-	Ĕ	resulting in death) Last Due to	(or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical	d					
ထ	ing p	Me	IF FEMALE:					
90	ath o	lan/	23b. Was decedent pregnant 1 Live b		Ectopic pregnancy		23d. Date of delivery Month Day	Year
P.O. Box	the a	Physician/Me	1 ☐ Yes 2 ☒ No 4 ☐ Pregr 9 ☐ Unknown 9 ☐ Unknown		Other (specify)		Month Day	1 841
	that the death certified by the attending detached for use as	Ph	Part II. Other significant conditions contributing to de	eath but not reculting in the ur	adorhing anuan auron in Bort I	220 Did tobacc		use of death?
JS,	Se Co	by	CAD	eath out not resulting in the th	idenying cause given in Fait i.		o use contribute to the car 2  No 3 Probably	
0	w requir been si should I	Completed	- 1 - V			1 103		
ec Sec	hast ge 2 s	Jqr				24a. Was an autopsy	24b. Were autopsy fi prior to complet	indings available tion of cause of
<u> </u>	cate					performed? 1 ☐ Yes 25€ 1		No
<u>=====================================</u>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		Othor	h (Check only one)		
o	Phys this al dir	5	10.162 5\$7.40	npatient 2 ER/Outpatient		me 5 Residence		
Z C	ding h. After funer	<u>6</u>	1 Natural 5 ☐ Pending (Mont	of Injury 28b. Time of Injury Injury	Work?	28d. Describe how inj	ury occurred	
<u>s</u>	Attending r death. ector: After by the fune	Cal	2 Accident investigation 3 Suicide 6 Could not be 280 Place	of laius. At home form etr		296 Lagation (Chant	and Number of Control	
Division of Vital Records,	or A after Direct in by	Certification:	4 Homicide determined 206. Place buildi	of Injury - At home, farm, streng, etc. (Specify)	вет, тастогу, опісе	City or Town, Sta	and Number or Rural Rou ite)	ite Number,
_	spita ours seral filled		29a. Certifier	best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(c) and manner as stated	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2   Medical Examiner: On the ba	asis of examination and/or inv	restigation, in my opinion, death occurr	red at the time, date a	nd place, and due to the	cause(s)
	를 들 들	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day,	Year)
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)	4 3 5 8		A W AIITIIM		D-54X6X	1/11/	1. 19. WUL	
(			30. Name and address of person who completed caus	e of death (Item 23a) (Type, I	Print) D - 54 868	Isn	× 19, 2004	
(	\$ 2 s		30. Name and address of person who completed caus	e of death (Item 23a) (Type, F	Print) D-54868	4 5D	ient, und	<b>S</b>
(	Sta Registr		11051 Little Pothwas	101.		y 5D	iench, mo	3

State of Maryland / Department of Health and Mental Hygiene For State Registrar 2020 Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:15 Lucille August 18, 2004 D Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adventist Health Care Sligo Creek Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🖸 F 3/29/1916 578-22-9200 88 Director Maryland Usuel Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Tyes 2 □ No Director Loudon Virginia Leesburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 23a 18440 Kapalua Terrace 20176 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Hems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: þ 3√2 Widowed 4 □ Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Elevator Operator Federal Government other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any july or other treumatic event 2008. Be Rosie Unknown Charles Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Burrell - Daughter 18440 Kapalua Terrace, Leesburg VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/23/2004 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Misalin T. Klobert 3401 Bladensburg Rd; Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cornary Artery Disease /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Que to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown ģ signed by the period Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Dunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular Accident with aspiration (chronic) 24a. Was an has autopsy performed? page 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: XX Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an ditle of certifie D 20362 who completed cause of death (Item 23a) (Type, Rint) 130n MD 6525 Belovest Rd Hyntsville MD 20782 vorton

State Registrar

31. Date filed (Month, Day, Year)

**AUG 25** 

DHMH 17 Rev 1/2001

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer 22:10 P M **Physician** Clarence Bell 13 04 08 /Medical 4c. County of Death 4b. City. Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince Georges Cheverly Prince Georges Medical Center 8. Date of Birth (Month, Day, 06 09 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Washington, D.C Months Days Hours 1X M 2 F 71 579-44-8716 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Mudical Examiner must be richlified at 1√ Yes 2 No Washington Director D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23s 20019 USA 3706 Grant Place N.E. Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married 1 XYes 2 No 1955-1 ☐ Yes 2 No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1957 "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) then Elementary/Secondary (0-12) D.C. Public Schools Teacher 4 yrs. marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fand Mental Edna Gray William Bell permit. Pages 1 and 2 shoul Department of Health and Mitmportent: If Item 27 is mark any injury or other traumathonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1115 McCullough Ct. N.W. #302 Washington, D.C. 20001 Devra Williams /Cousin altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Triangle, VA. 8-23-04 Quantico National 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA FATAL **Physician** /Medical Due to (or as a consequence of): HYPER TENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DIABETES MELLITUS The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. sician KENAL Physician/Medicai the phys as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day to 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe has page performed? 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🕱 No this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) med, ms 30. Name and addregof person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20185 3001 HOSPITAL LITTLE, MD 38. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 25 2004 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Danita L. Baker-Lisane Day Year :4/5 pM 18 /Medical 400051 3004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Lanham 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Nov. 26, 1960 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral**  Birthplace (State or Foreign Country) 1□M **¾**□F 43 343-58-1384 Director Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28e-f shor other traumatic event. The Madical Evantiner must be notified at P.G. Riverdale Md. Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6815 Riverdale Road #4 20737 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Be Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Essectial Office Techn. 12th Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Hosea Tisdale Jennvia Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other train once. Edwin Lisane (Son) 6815 Riverdale Road #4, Riverdale, Md. 20737 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 □ Cremation 3 □ Removal from State Cedar Bluff Cem. 8/28/2004 Rockford, Illinois ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tri-State F/S/Inc. 21. Signature of Funeral Service Ligensee 912 Third St. N.W.Wash.D.C.20001 Lanco 23a. Part . Enter the disease, or com-shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** Advanced brast Canon disease or condition resulting in death) Unkuous /Medical Due to (or as a consequence of) Examiner Malignant Duun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unknows Due to (of as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death I Director: After t d in by the funera Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funaral C

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rait Fall MA D43446 8/19/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. MD 4861 Georgia Aresnit 3_41 Silver Spring MD 20902 ROINTAN FAR AHIFAR MD 31. Date filed (Month, Day, Year) State AUG 2 5 2004 Registrar

LISAWE,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17 **Physician** Year Broadus August 2004 /Medical 7:15 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince George | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August | 8,1939 | South | Carolina 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Director 579-50-2494 65 Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location or 28e-f show 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No Maryland Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3702 Excalibur Court #301 20716 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature" any injury or other traumatic exercises. Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seventh Truck Driver Moving/Storage Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Eugene Broadus Sr Elizabeth (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Broadus/Wife 3702 Excalibur Court #301, Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State August 24. Mt Olivet ^¹ 4 □ Donation 5 □ Other (Specify) Washington, DC 2004 21. Signature of Juneral Service Licensée 22. Name and Address of FacilityRobert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 almas 2a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) an anown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) Dav Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Winknown peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Yes 2 2 1 Impatient his 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie ical (Check only one) Medi To the 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 167 or n who completed cause of death (Item 23a) (Type, Print) Ives JPRING MD 20902 Ave 3-41 31. Date filed (Month, Day, Year)
AUG 2 5 2 . Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year ANDREW BELL AUG. 9:15 P M JAMES 2004 21, /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner ^{4a}MARINER⁽⁾⁽HEALTH, OF Street and Lumber) 5721 GROSVENOR LANE BETHESDA MONTGOMERY If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Y 3-25-16 Birthplace (State or Foreign Country)
 MS Funeral Months Days Hours Year) Min. 88 Director 425-18**-**1136 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examinar must be notified at Yes 2 No Director DC WASHINGTON the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140 - 48TH PLACE, N. E. or itams 23g 20019 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Specify: BLACK Year or Dates: naturai Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 1 YEAR POSTAL EMPLOYEE U. S. POST OFFICE ges 1 and 2 should be filed vot Health and Mental Hygie If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLEOPHUS BELL HATTIE L. ပ BINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEIDRA J. BELL-DAUGHTER 140 - 48TH PL., N. E. WASH., DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If its
any injury or ott 1 Burial 2 Cremation 3 Removal from State LINCOLN MEMORIAL CEM: 8-27-04 4 □ Donation 5 □ Other (Specify) SUITLAND, MD 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Paysician CARDIONYOPATHY LONG ESTIVE /Medical Due to (or as a consequence of): Examiner PARKINSONS SEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 X No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 124 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 1-27660 AUGUST 23, 2004 person who comp eted cause of death (Item 23a) (Type, Print) 30. Name and address of 0 ALPANA GOSWAMI, 11119 ROCKVILLE PIKE #G100 ROCKVILLE, MD 20852 M D. 31. Date filed (Month, Day, Year) AUG 23 2004 State Registrar

B.K.S ADRIENNE M.			Ink. Ensure All Copies of Health and Mental Hy	_
		Certificate		
Physician	1. Decedent's Name (First, Middle, Last)  ADRIENNE MICHEI	LLE BRO	2. Date of De Month AUG.	30, 2004 3. Time of Death 0800 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 412 71st. AVENUE	4b. City, T	fown, or Location of Death EAT PLEASENT	4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 6. Sex X 7. Age	(In yrs. last birthday) If Under Months Months	1 Year If Under 24 Hrs. 8. Date of Bir Days Hours Min. 5 - 2 1	9. Birthplace (State or Foreign NEW YORK
and **	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
r 28e-f show	MD PRINCE GEORGES	CAPITOL HEI	GHTS	1 X Yes 2 No
vith the Mar or 28e-f sh tensilitied Director	10e. Street and Number	10f. Zip		10g. Citizen of What Country?
siter death was tems 23s.	412 71st AVENUE  11. Marital Status  12. Was Decedent E	ver in U.S. 13. Was Decede	20743 ent of Hispanic Origin? (Specify Yes or No	U.S.A.  14. Race - American Indian,
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28e-1 show sical Exercipes trivial be notified at eted by Funeral Director	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ No.  3 ☐ Widowed 4 ☑ Divorced Year or Dates:		ify Cuban, Mexican, Puerto Rican, etc.) ☑ No Specify:	Black, White, etc.  Specify: BLACK
15-003 72 hours "natural", solical Exi	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual (Give kind of work	I Occupation k done during most of working e retired)	16b. Kind of Business/Industry
nd 21215-00 sitied within 72 hou il Hygiene. other than "natura rent, the Medical te Completed	Elementary/Secondary (0-12) College (1-4or 5+	-)	TION SPECIALIST	Private
Waryland 2- 12 should be filed v 12 should be filed v 18 marked other t traumatic svent. ID. To Be Co.	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle	
Vial bould b Ment Ment warked natic s	HAROLD BRO		GLORIA	McDONALD
ore, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours aft of Health and Mental Hygene. Iftem 27 is marked other than "natural", or r other traumatic event. Its Medical Exercit To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) VIOLET CURTIS - COUSIN		(Street and Number or Rural Route Numb ${ t LEY \ PARK \ ROAD}$ , S	EAT PLEASANT, MD
	20a. Method of Disposition	20b. Place of Disposition (Nam cemetery, crematory or of		20c. Location - City or Town, State
Baltimore, sernit. Pages 1 ar appartment of Hea mportent: If item in injury or other bace.	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	RIVERDALE PA	ARK CREM. 9/7/04	RIVERDALE, MARYLAN
Baltimo permit. Pag Department Importent: I any injury o once.	21. Signature of Funeral Service Demise		d Address of Facility TAYLOR'S NORTH CAPITOL ST	
Fhysician /Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ensive cardiova		rrest, Approximate interval Between Onset and Death
68760, tificate be executed to physician and as the burial-transit	Cause (Uisease of injuly that initiated events resulting in death) Last  C. Due to (or as a d	consequence of):		
Box death cer e attendir d for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No Unknown  23c. If yes, outcome of the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the p	2 ☐ Fetal death 3 ☐ Ectopic pre		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death bu	t not resulting in the underlying ca	<b>3</b>	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
f Vital Records, P.O. ysiclen: The law requires that the is certificate has been signed by the director, page 2 should be detached. Be Completed by Phys			24a. Was auto perfo	
Jn of alling Ph	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation		8c. Injury at Work? 1 Yes 2 No	idence 6X10ther (Specify) AT SCENE how injury occurred
Divis	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, street, factory . (Specify)	r, office 28f. Location ( City or To	(Street and Number or Rural Route Number, wn, State)
Divisic To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the Medical Certifical		examination and/or investigation,	at the time, date and place, and due to the , in my opinion, death occurred at the time,	
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CR	Juffor locke M	·/	reet, Baltimore, Mar	ryland 21201
State Registrar	31. Date filed (Morlth, Day, Year) SEP 0 2 2004	Ts Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) August 2**00**4 1505 P M **Physician** Dona1d Boozer /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death **Examiner** Prince George Cheverly P.G. County Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, 8. Date of Birth 9. Birthplace (Stere of Geign (Month, Day, Yeer) 2,1938 Washington If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 15√ M 2□ F 65 578-50-3548 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at Yes 2 No Maryland Prince George Hyattsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6423 Landover Road #201 20785 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 8/23/57—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 8/24/59 1 ☐ Yes 2 🗓 No Specify: Black Specify ģ 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sears and Roebuck College (1-4or 5+) Flementary/Secondary (0-12) Truck Driver Twe1th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Boozer Vivian Knox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5207 Newton Street #202, Bladensburg, Maryland 20710 Donovan Lloyd Boozer/Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Department of Important: If any injury or 8/30/04 Triangle, Virginia Quantico National * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licens 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 23a. Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): days Examiner failur Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Directo for an alegangaquence offi lor Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month in the past 12 months? ģ 4□Pregnant at time of death 5 Other (specify) detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2∏ No 1 Yes 2/2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ 4 Homicide filled in o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 8/25/04 D0053709 Keym MD 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Bowie m) 20716 mitchellville CHAWLA 201 3060 KAT. K. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 2 6 2004 Registrar

DHMH 17 Rev 1/200

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1604 PM Augus 2004 Cherry Dorothy Gates /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Keninsula Regional medical Center alisbur If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Davs Months 1 □ M 2X F 68 July 15, 1936 Washington, D.C Director 579-48-6197 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State show ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 4340 Ramblin Road by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 4+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be markad Margaret Gates Theodore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4340 Ramblin Road, Salisbury, Maryland Health Itam 27 I (husband) David Earl Cherry 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 XOther (SpeEntombment Wicomico Memorial Park August 23,2004 Salisbury, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral HOme Professional Association 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Road, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Pacumonia **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Uncarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
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Director: After t 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

Dorothy To the Hospital or within 24 hours afte To the Funeral Dir 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tine of certifier m.D. 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. , 501.3300g 1.0. James E. MAYRTIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 9 2004 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

			1 - For Stata Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H		d Mental Hy	giene	11. 281.06
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death
	Physic /Medi		Shirley Cr	eighton				August	Day 20	004 10:05 a. ^M
	Exami		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of De		4c. County	
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	Funeral		5. Social Security Number 6. S 214-07-7705	ex 7.Ag 1521 M 2 □ F	pe (In yrs. last birthday) QQ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	,	89 Yrs.			July 2	2, 1915	Maryland
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Q	ath w	ral	107 Willis St.				21613		U.S.	Α.
R	er de	Funeral	11. Marital Status	12. Was Decedent Amyed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race Blac	e - American Indian, k, White, etc.
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Maryland 21215-0036	within 72 hours after death with the Maryland ane. than "neturel", or liems 23e or 28e-f show he Madical Examinar must be notified at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/Industry
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lar	2 short and Is m		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	and Number or	Rural Route Numb	er, City or Town, S	State, Zip Code)
e)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examenar must be notified at once.		Mary Ann Creight  20a. Method of Disposition	on	107 20b. Place of Dispo	Willis St	Camb			
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		-	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, I	Print)			0,20,0	/
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year LOWELL AUGUST 21, EUGENE CAMPBELL 2004 12:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7351 Willow Road, Cll Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer)

Months Days Hours Min. June 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Director 296-18-7331 84 1920 Ohio Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7351 Willow Road, C11 21702 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 No þ White If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) es 1 and 2 should be filed wi of Health and Mental Hygien If item 27 Is marked other th Agricultural Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Guy Campbell Grace Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah K. Campbell / Wife 7351 Willow Road, Cll Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o þ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State August 23, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Frederick, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) cancer luna /Medical Due to (or a a consequence of): Examiner tobacco use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to [or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cancer, atrial 1 Yes 2 □ No 3 Probably 4 □Unknown macu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Dey, Year) D00 43389 August 23, 2004 30. Name and address of person cause of death (Item 23a) (Type, Print) 198 Thomas Johnson Dr#200 Frederick MD 21702 15+ B. Brinkley Jusan MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Document of Booth and Montal Divisions	Oppurion or result and wester tryjens. Important: if items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be multified at	ODCO
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	-	1 - State Registrar			Cer	tificate of l	Death		1	Reg. No.	104	281.09
Dhualaia		1. Oecedent's Name (First, Middle, La	•						Date of Dea	Day	Year	3. Time of Death
Physicia /Medic		CHARLES HAROLD CA	RROLL					A	UGUST	25, 2	004	3:03 P M
Examine	er	4a. Fecility Name (If not institution, gir		10		4b. City, Town, or	Location of	of Oeath			ty of Death	
	-	SOUTHERN MARYLAND				CLINTO	N If Under	24 Ura   a	0 ( D)		CE GE	
Funeral Director			1 DM 2 DE	69 (In yrs. last bir	Yrs.	Months Days	Hours	Min.	Oate of Birt (Month, De ULY 4,			olece (Stete or Foreign ntry) YLAND
anyland show	t	10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside City Limits
the Mary 28e-f sh notified	Director	MARYLAND CHARL  10e. Street and Number	ES	NAN	JEMC	Y 10f. Zip Code				10g. Citizen o	f What Cou	1 X Yes 2 □ No
ath with s 23a or		8675 VIKINGSON PL			1	20	662			UNITED	STAT	ES
10 O L	by Funeral	11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent If Armed Forces?  1 Tyes 2 The If Yes, Give Year or Dates:			/as Decedent of Hi Yes, specify Cuba ☐ Yes 2∰No	Specify:		y tes or No-	Spec	ace - Americack, White,	
72 hours "naturel",	ted	15. Decedent's E (Specify only highest gi	ducation	16a.	Deced	ent's Usual Occupa	ation	st of working		16b. Kind of		
on han	Completed	Elementary/Secondary (0-12) 7TH GRADE	College (1-4or 5		life. C	O NOT use retired		n or morning		CONCE	DIIOMT	O.M.
Hygie ther t nt, th		17. Father's Name (First, Middle, Las	1)		LABC	KEK	18. Mothe	er's Name (F	irst. Middle.	CONST		JN
2 should be filed within 72 and Mental Hygiene. Is marked other than "na aumatic event, the Medic	To Be	CHARLIE VINCENT C						JACK				
s 1 and 2 should be tited within 72 hr Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical		19a. Informant's Name/Relationship THERESA JOHNSON /	•	1		Address (Street a						
es 1 a of Hez of item r othe		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of	Dispos	ition (Name of atory or other plac		Date		20c. Location		own, State
Pages tment of tant: If it jury or o	1	`4 ☐Donation 5 ☐ Other (Speci	(y)	MT. HO							EMOY,	MARYLAND
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tray		21. Sur ture of Funeral Service Lies	ON JOHNSON	M00583	TH	ORNION F	UNERA	L HOM	E, P.A	AN TITLA		OW AND GOOD
3	1	23a. Part1. Enter the disease, or con	plications that caused	the death. Do r	not ente	r the mode of dyin	g, such as	cardiac or re	espiratory ar	rest,	D, MAI	Approximate Interval Between
Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each in	ohic	3	nock						Onset and Death
/Medical	ì	resulting in death)	a. Due to (or as	consequence	of):		1		hee	tast	(	
Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to lor as	a consequence	of):	e C	3(0)	nc		4434	28	
pe tis	Exan iner	Cause (Disease or injury	Par	(. 1)7	re	cumi	a:					
be executed icien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):						-	
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entificate ding physice as the b	ledicai											
To the Hospitel or Attending Physician: The law requires that the death certificate be execused within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					ate of deliver	ery Day Year
that the hold by detac		Part II. Other significant conditions	contributing to death bi	ut not resulting in	the un	derlying cause give	en in Part I	l.	23e. Did to	obacco use co	ntribute to t	he cause of death?
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he law re has bec ge 2 sho	Completed								24a. Was autop perfor	an 24b rmed?	death?	psy findings available mpletion of cause of
in: Ti	ပိ	25. Was case referred to medical	I				26 Place	e of Death (C	1 Yes	2 No	1 🗆 Yes	2 No
/sicie s cent direct	0 0	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	nt 2 ER/Ou	tpatient	3□ DOA Othe	or			tence 6 🗆 O	ther (Specif	v)
g Phy gerthii	- L	27. Manner of Death	28a. Oate of Injur (Month, Day		Fime of	28c. Injury Work	/ at			now injury occu		,,,
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To the Hospitel or Attending Physician: The law within 24 hours after death with the funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exe	hysicien: To the best of miner: On the basis of and manner sta	examination an	death d/or inv	occurred at the timestigation, in my op	ne, date an pinion, dea	nd place, and ath occurred	due to the dat the time, d	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
To the within to the comp	Ž	29b. Signature and title of certifier	1 94	COND	14	29c. License	2420	73		29d. Date sign		Day, Year)
^		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, F	Print)						
MPI		ABULHASAN U. AN					RD RO	AD. SI	ITTE 10	01. CLT	NTON	20735 MARYLAND
Sta		31. Date filed (Month, Day, Year)	20 D-4-4	ar's Signature				, 00		<del>,</del>		TWNILAND
Registra	al C	AUG 2 7	ZUU4 2000	was sign	19	- Care						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician VONNA MAKIE 10:30 AM CARR 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital Oakland Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Dec | 25 / 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F 219-44-0668 Maryland **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits Show rthan "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at MD Garrett McHenry 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21541 6239 Sang Run Road USA death v 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Garrett County Board Etementary/Secondary (0-12) College (1-4or 5+) Vocational Assistant of Education permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other it eny injury or other traumatic event, Ite once. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Leo Paugh Rilla Elizabeth Glotfelty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Carr/husband 6239 Sang Run Rd., McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sang Run Cemetery, Aug 25, 2004 McHenry, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatyre of Funeral Service Newman Funeral Homes, P.A., PO Box 275 jumae. 179 Miller St., Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Finat disease or condition resulting in death) Physician CARCINOMATOSIS (UNKNOWN ABDOMINAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has blirector, page 2 s 1 ☐ Yes 2/2 No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 PNo After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat • Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office pilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Markor Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifie er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature as August 21,2004 D51564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PYTHING AVE DAKIND MG 21550 10 ZAKALKZNY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **AUG 23** 2004 Registrar

**ORIGINAL** 

				State o	f Marylar		artment of rtificate o		and Mental Hy	/giene Reg. No?	01. 2	21.10
	Dhysis		1. Decedent's Name (First, Middle, Le	est)			<u>.                                      </u>		2. Date of Do	eath Day	Year	3. Time of Death
	Physic /Medi		Pauline Swisher (	unningh	am				August			:40 PM
j"	Exami		4a. Facility Name (If not institution, gir					-	vn, or Location of Dear		y of Death	
Ĺ			Goodwill Retireme						sville, MD	Garet	St -	
ı	Funeral Director		234–36–6639	Sex 1□M 2DXF	7. Age (In yrs. 81	• • •	If Under 1 Year Months Day		Min. 8. Date of Bi (Month, Do Octobe)	r 26, 19	22 Country)	e (State or Foreign
	and w.		Usuat Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d	Inside City Limits
	Maryl	চূ	WV Harris	on	Bri	ldgepor	t					1 XXYes 2 □ No
	28e	iec.	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	?
	h with	a D	600 Deerfield Dr.					26330	ם ا		USA	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evantinal to notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2□(Married 3 □ Widowed 4 □ Divorced		2 🔯 No e		Was Dacedent of fYes, specify Cu 1 □ Yas 2 🔯 No		in? (Specify Yes or No Puerto Rican, etc.)		ce - American ick, White, etc. fy: White	
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anc	be fi	Be	17. Father's Name (First, Middle, Less Willie Ray Liston						's Name (First, Middle	, Maiden Surnai	ne)	
ž	hould d Mer marke	ဥ	19a. Informant's Name/Relationship			10h Mailir	a Address (Care	Tay (			C1-1- 7'- C-	4.1
Maryland	d2sl then 7 is r treur		Raymond Cunningha		band		eerfiel		ror Rural Route Numb Bridgeport			de)
ē,	Heal		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Date	20c. Location	- City or Town,	State
9	ages ent of it: If it		1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		state		netory or other p	ace)	8/24/200	Fairmor	nt, WV	
Baltimore,	nit. F Sertmoortar injur		21. Signature of Funeral Service Lice	•	FIS	gah Ce	. Name and Add	ress of Facility		<i>J</i>		
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68760,	Physician   American	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fairly, leading to inity distributed sease. Enter Underlying Cause (Disease or injury that initiated events	a A DV A	Due to (d	or as a conseq	uence of):	SONS	S DISE	4sE		
Box 687		n/Medicai	resulting in death) Last	d	Due to (o	r as a conseq	uence of):					
B	death	sicle	Part II. Other significant conditions of	contributing to de	ath but not res	ulting in the ur	nderlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
S, P.C	v requires that the death certif been signed by the ettending should be deteched for use a	by Physiclan/M	GENERAL I	ECLIA	JE,	ANOR	EXIA		1	Yes 22 No	3 Probabi	y 4 □ Unknown
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ō	Physi this c	<u>۲</u>	1 ☐ Yes 2th No 27. Manner of Death	1 1 1	npatient 2	ER/Outpatien 28b. Time of	1 3LI DOA		sing Home 5 Resi			
on	ding h. After fune	Ē	1 X Natural 5 ☐ Pending		n, Day Year)	Injury	28c. Inj W M 1[	ork? ⊡Yes 2⊡N		how injury occur	rea	
Division of	or Attendii efter death. Director: A I in by the fu	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of Injury - At he g, etc. (Specif	ome, farm, stre	eet, factory, office			Street and Numb wn, Stete)	per or Rurel Ro	oute Number,
	To the Hospitel or Attending Physicien: The law within 24 hours effect death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Property 2 Medical Example 1	nysician: To the laminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred et the restigation, in my	ime, date and opinion, death	place, end due to the occurred at the time,	cause(s) and madate and place,	anner as stated and due to the	d. cause(s)
	To the Vithir Comp	Me	29b. Signature and title of certifier				29c. Licer	se number		29d. Date signe	d (Month, Dey	, Year)
			1 Kor B	me	0,	nis	Dos	342	3/	DINO	21	2004
		f	30. Name and address of person who	completed cause	of death (Iten	n 23a) (Type, I				14000	5 - 1	
			Robin Biss-				niller 5	+, 6	rantsuille	nd	21536	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2		egistrar's Signa	iture	Angert's 5	1				

			Please Type or Print in Black II		•	<del></del> .
			, FOI	partment of Health and Ment e <i>rtificate of Death</i>		
	B) I i		1. Decedent's Name (First, Middle, Last)		Reg. No	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Mariner Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Glen Burnie	ate of Birth	Anne Arundel  9. Birthplace (State or Foreign
	Funeral Director		217 16 4106 1□M 2 F 82 Yrs.		-15-1922	Maryland
	uryland bhow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	8a-1 oullie	Director	MD Anne Arundel Glen Bu		140-0	
	h with it	al Dire	313 Hospital Drive	10f. Zip Code 21061	-	citizen of What Country? nited States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No-	14. Race - American Indian, Black, White, etc.
980	d within 72 hours after death with the Maryland isiene. T then "naturel", or Items 23e or 28e-f ehow Items Wedical Examiner must be motified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	,,	Specify: White
Maryland 21215-0036	in 72 ho "natur ed cal	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b.	Kind of Business/Industry
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b	be filed that Hygie d other there	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		n Sumame)
<u>Ja</u>		2	Tom Flinn	Edith Shock		
Mar	12 sh h and 7 ie m traum		, , , , , , , , , , , , , , , , , , , ,	illing Address (Street and Number or Rural Rou Heming Ford Ct. West		
	~ 1 5 5		20a. Method of Disposition 20b. Place of Disposition	position (Name of Date rematory or other place)		Location - City or Town, State
E			1 ⊠Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)  Baltimo	re Nat'l Cem. 8-19-20	04 Bal	ltimore, MD
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee M01044	22. Name and Address of Facility Harry 4112 Old Columbia Piko	H. Witz	ke's Family FH Inc. ott City, MD 21043
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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o.	0 0 2	Physician/Medic	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
s, P	es tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Record	w requir been s should	letec	Deforces sion huneli bidous		24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed	Mishible Coulsactura		autopsy performed? 1 Yes 2	prior to completion of cause of death?
Vital	Ician: Th	Be	25. Was case refer to medical examiner?	26. Place of Death (Chi	eck only one)	
of V	S S S	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			6 ☐Other (Specify)
	fte	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time Injury (Month, Day Year)		Describe how inj	ury occurred
Division		icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		ocation (Street a	and Number or Rural Route Number,
Ω	after after I Dire	Certification:	4 Homicide determined 209. Flace of injury - Arthority, building, etc. (Specify)	(	City or Town, Sta	te)
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and d investigation, in my opinion, death occurred at	due to the cause( the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the Ho within 24 to To the Fu completely	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			Affending Physician	D 29873	8	117/04
	(40)		30. Name and address of person who completed cause of death (Item 23a) (Type RITA CHANDELWAL, M.D.	18. Print) Goos Crain Hw	Y,# 61	o Glen Burge, We
	Sta	ate		Socie	-	
k	Regist	rar	AUG 1 8 2004 Seem St.	goerle)		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Yutha Chavis 2004 August 17, 9:15 P.m /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Prince George Larkin Chase Nursing Facility 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1XF 82 Virginia 226-24-9240 1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Largo MD Prince George Funeral Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code **USA** 500 Harry S. Truman Dr. #413 20775 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Switchboard Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) å Olivia Dodson Willie Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3194 Berry Rd, NE Washington, DC Jewel Senior/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/19/04 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeak Crematory 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licensy 6500 Allentown Rd, Camp Springs, MD 20748 Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, life one cause on each line. enter the disease, or color or heart failure. List only Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical relmanae Examiner Physician/Medical Examiner Attending Physician: The law raquires that the death cartificate be executed for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ٥ Aftar this cartificata has bean signs funaral diractor, paga 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 11 Yas 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No daath. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 [7] Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide ō To the Hospital c within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) HOPRA MD. 600 Ridgely Ave. Stc. 231 Annapolis, MD. 21401 31. Date filed (Month, Day, Year) State AUG 2 5 2004 Registrar

			1 - For Registrar	State of Maryland /	Depart		lealth and N	Mental Hyg	_	n i	00110
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	SPO				2. Date of Dea Month	Day	2004	3. Time of Death
	Examir Funeral Director		4a Facility Name (If not institution, give Processing of the William Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of the Processing of t	National Pike	irthday)	DUNT 1 Under 1 Year Nonths Days	If Under 24 Hrs. Hours Min.	nary and 8. Date of Birth (Month, Day Dec. 13	1	9. Birth	place (State or Foreign entry)
	Maryland a-f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Montgon	10c. City, To		ion				7	lod. Inside City Limits
	3s or 28	al Director	10e. Street and Number 25621 Coltrane Dr	ive		10f. Zip Code	20872		10g. Citizen of Unite		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner mast the motified at ance.	Completed by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Bla	ce - Americk, White, fy: Whi	etc.
1215-0	within 72 ho ene. then "natur he Medical I	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	(e completed)  College (1-4or 5+)	a. Decedent (Give kind life. DO		ation during most of won d)	king	16b. Kind of E	susiness/In	dustry
$\subseteq$	should be filed ind Mental Hygis marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Claudio Crespo				Carmen	re (First, Middle,	Maiden Suma		
, Mar	and 2 sh alth and 27 le m er traum		19a. Informant's Name/Relationship (T) Carmen Azcuy/ Daug	ghter 2	5621 (	Coltrane		It Airy,			Code)
Itimore	permit. Pages 1 and 2 Dept riment of Health a Important: If item 27 is any injury or other tra <u>once.</u>		20a. Method of Disposition  1 ☐ Burial 2 X Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Segn@ Licens	Ft. L	incol:	on (Name of ory or other place on Cremat	tory 8/2	-	20c. Location  Brentwo		
Ba	Deperming Important		> FV		340.	r gradei	ss of Facility n Funeral nsburg Ro	ad Brent		MD 20	722 Approximate
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the	a. Broncho-pneumo Oue to (or as a consequence b. Alzheimer's De Due to (or as a consequence	onia • of): ementi						Inférval Between Onset and Death ne Week.
ox 68760,	eath certificate be executed attending physician and for use as the burial-transit	cal	resulting in death) Last	Due to (or as a consequence  d					23d. Da	ate of delive	907
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rds, Р	w requires that been signed b should be deta	d by Pl	Part II. Other significant conditions con Non Insulin Depe	•		, , ,	en in Part I.				ne cause of death?
Division of Vital Records,	The law requires that the death centrica rate has been signed by the attending phi page 2 should be detached for use as th	Completed	Hypothyroidism.		· · · · · · · · · · · · · · · · · · ·			24a. Was a autops perfor 1 Yes	sy med?	Were autoprior to codeath?	psy findings available mpletion of cause of
Vita	sician: certific iractor,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	utnations	3 Oth	O.C.	th (Check only or	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(C)	
sion of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	-	Time of Injury	28c. Injun World M 1	4.5	ome 5 Resid			<i>n</i>
DIX	oital or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				28f. Location (S City or Town	n, State)		
	the Hospital hin 24 hours a the Funeral C mpletely filled	edical	29a. Certifier 1∑ Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death oc ind/or invest	ccurred at the tin tigation, in my o	ne, date and place, pinion, death occur	, and due to the c rred at the time, d	ause(s) and m late and place,	anner as s and due to	tated. the cause(s)
ı	To the within To the comple	Σ	29b. Signature and title of certifier	elle b	>	29c. Licenso			19d. Date signe 19ust,		Day, Year) 2004
CA	20		30. Name and address of person who on N B Vellanki, MD;	ompleted cause of death (Item 23a 9055 Chevrolet 1			e 100, El	licott C	ity, M	210	42.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5 2004	39. Registrar's Signature	1.						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Aug. 21, 2004 6:35 P M <u>Nellie E. Carlson</u> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 14, 1912 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 361-34-1931 1 □ M 2 🛛 F 91 Illinois Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at Director Rockville Md. Montgomery Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701-Veirs Drive 20850 USA death Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iten any injury or other treumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: White Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Aide Health 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie Kate Bratton Calvin H. Loso ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9701-Veirs Dr., Rockville, Md. Rev.Dr.Reichard- Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory-8/24/04-Alexandria, Va. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Se 22. Name and Address of Facility Hysong Co., Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Cardiactor respiratory arrest. DC shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONHESTIVE FAILURE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit REVAL INC Due to (or as a consequence of): IN CUFFICIE MCY resulting in death) Last Records, P.O. Box 68760 by Physician/Medical HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the at id be detached for 4 Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending Injury after death.

Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D Hospital icai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mulle Dus 2004 DO051158 AUGUST 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20850 VEIRS DRIVE ROCK VILLE VATTI.T. ANTHONY 9701 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 2 6 2004 Registrar

A   Secular Name (fine institution, give streat and number)   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cutter   A   Cu			Decedent's Name (First, Middle, L	erMD, FCHD,				2. Date of Dea	Reg. No. U	3. Time of Death
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16. Designer's Essections   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Business/Industry   16. Control of Busine	5	ğ	Maryland Freder	ick	Bru	unswick				1 <b>X</b> Yes 2 ☐ 1
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16a. December   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Superior   Supe	C ie	2	3 Sheridan Lane			21	716		United	States
16. Decedent's Exception   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. Decedent's Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual Occupation   16. December of Usual O	200	e	11. Marital Status	12. Was Decedent	)	3. Was Decedent of H	lispanic Origin? (Sp	ecity Yes or No-	14. Race	e - American Indian,
16. Decedaring Escaption   16. Decedaring (Junal Coupstion   16. Seption of hyprograph gazes completed)   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Junal Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Decedaring (Juna Coupstion   16. Deceda	Ī	2	1 ☐ Never Married 2 🔀 Married	1 21 Yes 2 □	No IJ//-			Hican, etc.)		
Warred Charles Sr.   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 25 Code)			3 ☐ Widowed 4 ☐ Divorced		1997	TLI Yes 21 No	Specity:		Specify	Black
Warred Charles   St.	ptor	20			16a. De	cedent's Usual Occup	ation	ring 1	16b. Kind of Bu	siness/Industry
Securitially list conditions   20. Hyper and Address of Facility State   10. North Maple Ave., Brunswick, MD   21716   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Address of Facility State   20. Maring Add	inn	2			5+) I			,9	IIC D4	tal Camadaa
Warreb Charles, Sr.  198. Informant's Nama-Relationship (Type, Print)  199. Mailing Address (Street and Number or Purus) House Number, City or Town, State, Zig Code)  20a. Member of Disposition 1 Xigurial 2   Chemistrian 3   Removal from State   20b. Place of Deposition (Numer of Institution S)   Date   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, S	Š	5 -		2		Mail Handl				
Water Charles / Wife 3 Sheridan Lane Brunswick, MD 21716  20s. Method of Disposition   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   14 Constitution   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control   15 Control	B	0								θ)
Laura Charles   Wife   3 Sheridan Lane Brunswick, MD 21716	٤	2 _	Warreb Charles,	Sr.						
20a. Method of Disposition   Same of Comment   State   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Comment   Same of Com			19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	and Number or Run	al Route Number	r, City or Town,	State, Zip Code)
TRestrict   Committed places   Baltimore   National Cem. 8-25-04   Baltimore   MD				Wife			ne Brunsw	rick, MD	21716	
21. Signature of Funeral Service Licenses  22. Name and Address of Facilities and Examiner?  23. Signature of Funeral Service Licenses  24. Partl. Enter the Jestine. or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25. Partl. Enter the Jestine. or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25. Partl. Enter the Jestine. Or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  26. Partl. Enter the Jestine. Or complication that the last of conditions are conditions.  26. Partl. Enter the Jestine. Use only one district caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  27. In any cause of the such that the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of last of the last of last of the last of last of last of the last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last of last	1	1	•	Removal from State	cemetery, c	rematory or other place	ca)			
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A Part I. Enter the Jess Se, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval between Onset and Death Immediate Cause (Final disease or condition resulting in death).    Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):			/ sentrul S	taulon		1100 North	Maple Av	e., Bru	nswick,	MD 21716
IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Ves 2   No 9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   Ves 2   No 9   Unknown   1   Ves 2   No 9   Unknown   1   Ves 2   No 9   Unknown   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Ves 2   No 9   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest   1   Vest	r		(	b						
24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   20nknow   24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   20nknow   24b. Were autopsy findings availat prior to completion of cause of death? 1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examine? 1   Yes   2   No   1   Yes   2   No   26. Place of Death   (Check only one) 27. Mannar of Death   5   Pending   28a. Date of Injury   28b. Time of Injury at Work? 28a. Date of Injury   28b. Time of Injury at Work? 3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Ho	ai Examine	LYD	that initiated events	c. Due to (or as						
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examiner?    Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex   Sex	by Physician/Medicai	by i hysicial medical Lya	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death t time of death	Other (specify)		1 ☐ Ye	Mon bacco use contri es 2 □ No :  In 24b. We be the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution	bute to the cause of death?  3 Probably 4 Unknow  Vere autopsy findings availation to completion of cause of
27. Manner of Death   Natural   S   Pending   Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time o	Completed by Physician/Medical	Completed by Hysician medical Lya	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death t time of death	Other (specify)	en in Part I.	1 Yes 2	bacco use contri	bute to the cause of death?  3 Probably 4 Unknow  Vere autopsy findings available from to completion of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause o
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  P16561  P16561  Angust 18, 2004	Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  contributing to death b	a consequence of):  of pregnancy 2 Fetal death t time of death but not resulting in the	☐ Other (specify)	en in Part I.  26. Place of Death	24a. Was a autops perform 1 Yes 2	bacco use contri	bute to the cause of death?  3 Probably 4 Unknow  fere autopsy findings available from to completion of cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  P16561  Amoust 18, 2004	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No	C. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death t time of death but not resulting in the	o Other (specify) underlying cause give	en in Part I.  26. Place of Deather: 4 □ Nursing Ho	24a. Was a autops perform 1 Ves 2	Mon  bacco use contri es 2 \( \text{No} \)  in 24b. W ey pr med? de 2 \( \text{No} \) 1 (e)  ence 6 \( \text{Other} \)	bute to the cause of death?  3 Probably 4 Onknow  fere autopsy findings available for to completion of cause of eath?  Yes 2 No
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  P16561  August 18, 2004	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  contributing to death b	a consequence of):  of pregnancy 2   Fetal death t time of death  out not resulting in the	ent 3 DOA Other of 28c. Injury Work	en in Part I.  26. Place of Deather: 4 \( \text{ Nursing Ho} \) / at	24a. Was a autops perform 1 Ves 2	Mon  bacco use contri es 2 \( \text{No} \)  in 24b. W ey pr med? de 2 \( \text{No} \) 1 (e)  ence 6 \( \text{Other} \)	bute to the cause of death?  3 Probably 4 Onknow  Vere autopsy findings available from to completion of cause of eath?  Yes 2 No
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			For	State of Maryland / Department of Health and Mental H	lygiene
_			1 - Stete Registrar	Certificate of Death	Reg. No. 2004 284 6
-	Physici /Medio		1. Decedent's Name (First, Middle, Las	Henry Dickerson 8	19 04 4:50 PM
	Examir	er	4a. Facility Name (If not institution, give	NU MUSELLA PACA OK	4c. County of Death
	Funeral Director		5. Social Security Number 6. Se 219 - 05 - 5030	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,	Birth Day, Year)  9. Birthplace (State or Foreign Country)
	yland	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	he Mar 28a-f s	ector	MD. Worce	ester Pocomoka	1 ÔXYes 2 □ No
	after death with the Maryland or items 23a or 28a-f show riner rivist be notified at	Funeral Director	1006 Marks	+ S+rea+ 21851	10g. Citizen of What Country?
		uner	11. Marital Status	Was Decedent Ever in U.S.     Armed Forces?     If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
5-0036	ours Engl	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:	Specify: Black
	"ne"	Completed	15. Decedent's Ed (Specify only highest grad	de completed) (Give kind of work done during most of working	16b, Kind of Business/Industry
2121	filad withii Hyglena. ther than int, the M	Comp	Elementary/Secondary (0-12)	College (1-40r5+) Security Guard	Outlet Store
and	d be filad intal Hygi ed other	Be	17. Father's Name (First, Middle, Last)	ckerson Hattie	lle, Maiden Sumame)
Maryland	2 should be and Mental Is marked aumatic ev	2	19a. Informant's Name/Relationship (7		nber, City or Town, State, Zip Code)
	s 1 and 2 should be filad withing Hoalth and Mental Hygiena. Item 27 Is marked other than other traumatic event, I'e. M.		Pegrl Purvell 20a. Method of Disposition	(Sister) 22 6 Works to Highway 20b. Place of Disposition (Name of Date	Po con-olo Ad, 21851 20c. Location - City or Town, State
mor			1 △Burial 2 □ Cremation 3 □  *4 □ Donation 5 □ Qther (Specify	Removal from State cemetery, crematory or other place)	Po cal a clife non d
Baltimore	permit. Page Department o Importent: If eny Injury or ence.		21. Signature Tune a/S vice Licens	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Homo
	40500		23a. Part1. Enter the disease, or comp	ilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory	arrest, Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a Carcinoma of Right Rung	Anoperable 3
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	
	pı is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	
,	ba exacutad ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	
8760	5 × 6	Ical	· ·	d	
Box 6	leath certificate attending phys I for use as the	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	23d. Date of delivery
	0 0 0	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
, P.O	requires that the d een signed by the nould be detached			ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?
Vital Records,	w requires been sig should b	Completed by	Trenlia	e Hypertension 10	Yes 2 No 3 Probably 4 Munknown
Rec	elaw hasb je 2 st	mple	Chrone K	C Y Per	topsy prior to completion of cause of death?
ital	ysician: Th is certificate diractor, pag	Be Co	25. Was case referred to medical examiner?	1 ☐ Yes  26. Place of Death (Check only	vone) 1 ☐ Yes 2 🔄 No
-	d is	၉	1 ☐ Yes 2 No 27. Manner of Death		sidence 6 Other (Specity)
ion	ath. r: After	atlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No	s now injury occurred
Division	or Atter de after de l'Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location City or T	(Street and Number or Rural Route Number, own, State)
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the tuneral	edical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	isician: To the best of my knowledge, death occurred at the time, date and place, and due to the iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
,			Krigoin h.	Sellers Mrs. D 29505  ompleted cause of death (Item 23a) (Type, Print)	08-20-04
27	1 DN.	1	GREGORIO M.B	ELLOSO, M.D.; 5302 CHINABERRY DR., SAL	LISBURY MD 21801
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22 FRANKYE **AUGUST** 2004 MAE DYE 5:37 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 27182 TIN TOP SCHOOL ROAD **MECHANICSVILLE** ST. MARY'S 8. Date of Birth (Month, Day, Ye, Aug. 25, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Days Months Hours Min. 1 M XXF 94 1909 Arkansas Director Yrs 441-16-4486 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examinations Le notified at Maryland Maryland Director St. Mary's 1 ☐ Yes 2 ☐ No Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27182 Tin Top School Rd. 20659 Funera USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No β White 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Pitts 2 Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Rebecca Bowie/daughter 27182 Tin Top School Rd., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Date 20c. Location - City or Town, State August 25, **=** 5 1 ☐ Burial 2 T Cremation 3 ☐ Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols crematory 2004 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee Locy P.A., P.O. Box 128, Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WW) disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by be 2 No funeral director, page 2 should Completed 1 🔲 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of after death. 28c. Injury at Work? 28d. Describe how injury occurred 1 Knatural 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) Fo the within 2 To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) **AUGUST 23, 2004** ress of pers o completed cause of death (Item 23a) (Type, Print) GEORGE WATHEN, M.D. PEMBROOKE SQUARE WALDORF, MARYLAND 31. Date filed (Month Day) ^v2^{r)}4 State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 20, 2004 7:05P [™] Garland Francis Dowling Aug. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3795 Maplecrest Dr. Knoxville Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Dec. 22, 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 24 LA 5. Social Security Number 6. Sex **Funeral** 1 M 2□F 578-44-6302 79 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be multiple at once. MD Frederick Knoxville 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 3795 Maplecrest Dr. 10f. Zip Code 21758 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) federal Elementary/Secondary (0-12) College (1-4or 5+) government attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Garland Dowling Emily Carbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Dowling (Wife) 3795 maplecrest Dr., Knoxville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burjal 2 ★Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8/25/04 Smithsburg, MD 5 ☐ Other (Specify) 21 9 ture of Funeral Service Levi ²²Donal Adres fathompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications that it used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheek, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENOCAPECINOMA OF PROTITE **Physician** YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Class (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) /s after dea...
sral Director: After tru...
> by the funeral direc' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled within 24 hours a To the Funeral L Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) and no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BRIAN M. O'CENNOR MD 501 W. SEVENTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2004 1620 JOHN FOUNTAIN DAVIDSON, SR. d /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Easton Memoria tospital albor II Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 ☐ F **79** SEPT. 29, 1924 Director 218-16-7553 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 611 LOVE POINT ROAD USA 21666 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ☐Yes 2XNo 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 10 CONSTRUCTION WORKER ROAD CONSTRUCTION marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PHILIP T. DAVIDSON PAULINE JACKSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARA DAVIDSON/WIFE 611 LOVE POINT ROAD, STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 08/31/2004 STEVENSVILLE, MD 21. Signature Francial Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Consestine Heart Jailuse **Physician** /Medical resulting in death) Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed and resulting in death) Last Due to (or as a consequence of): as the burial-P.O. Box 68760 attending physician Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ arrythemia Cardioc 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed disease Dulmonon 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed3 1 Yes 2 No Division of Vital the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Horou Laura Jin D55484 08-28-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAIOU LAURA JIN M.D., 219 S. WASHINGTON STREET, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 31

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			1 - State of Registrer	Maryland / Dep <i>Ce</i>	artment of H rtificate of L		ental Hygier	2000	28420
		7.0	Decedent's Name (First, Middle, Last)			1	2. Date of Death	-	3. Time of Death
	Physici /Medic	-	Phillip Edward Donelson			1	^	Lo Zoo	1520 M
	Examir	er	4a. Facility Name (If not institution, give street and numi		/	Location of Death		4c. County of Deat	h
	× - *			oital		If Under 24 Hrs.   8		Prince 6	evye's
	Funeral Director	i	5. Social Security Number 212–90–8294 6. Sex 2 F	. Age (In yrs. last birthday) 39 Yrs.	Months Days	Hours Min	B. Date of Birth (Month, Day, Ye 3/26/65	ar) 9. Birti	hplace (State or Foreign
			Usual Residence of Decedent				3/20/05	Bet	thesda, Md.
	yland		10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	a-fa	ctor	Md. P.G.	Springd	ale				1 Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
	23a	rail	3606 St. Johns Place			20774		U.S.A.	
	er de	nue	Armed Ford	ent Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	s afte	by Funeral	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date		1 🗆 Yes 2 🔀 No	Specify:		Specify: E	Black
8	72 hours after death with the Maryland Instural', or Items 23a or 28a-f ahow digal Examinar must be notified at	edt	15. Decedent's Education		dent's Usual Occupa	ation	16h	. Kind of Business/	Industry
15	n n	Completed	(Specify only highest grade completed)	(Give	kind of work done d DO NOT use retired;	luring most of working	9	. 11110 01 200111000	industry .
212	d within piene. rr than	E O	Elementary/Secondary (0-12) College (1-4 Vrs.	Commu	nications,	Social Wo	rker Ar	chdiocese	of Wash.
פַ	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (			
/lar	should be nd Mental marked c	70 E	Robert Donelson			W. Jacqu	elyne Ca	mpbell	
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artinent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow injury or other traumatic event, Ita Medical Examinar must be notified at a.		19a. Informant's Name/Relationship (Type, Print)  Judith E. Donelson/Wife			and Number or Rural			
	1 and 1 Health tem 27		•			ns Pl., Sp		, Md. 207	74
ore	of H of H if iten		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Si	20b. Place of Dispo cemetery, cre	osition <i>(Name of</i> matory or other place	Da Da	te 20c	Location - City or	Town, State
Ë	Pages iment of tant: If it jury or o		' 4 □ Donation 5 □ Other (Specify)	Harmony	Mem. Park			andover,	Md.
Baltimore,	permit. Pages 1 a Department of Hea Important: If item eny injury or otha once.		21. Signature of Funeral Service Licensee	2 4 4	^{2. Name and Addres} H.S.Washi 925 Burro	s of Facility ington & S ughs Ave.,	ons Co.,	Inc. hington.D	C. 20019
			23a. Part1. Enter the disease, or complications that cell shock, or heart failure. List only one cause on ear	used the death. Do not en					Approximate Interval Between
	Physician /Medical Examiner			oscleratiz	CArdioV	Agendar.	Heart	Disease	Onset and Death
В	日知。	7.	Sequentially list conditions, if any, leading to immediate b. Due to (o	r as a consequence of):					
	ted nsit	Examiner	Cause (Disease or injury	, 40 4 00.1004001100 01).					
	icate be executed physician and s the burial-transit	xar	that initiated events .	r as a consequence of):					
8760,	siciar siciar s buri	Sal							
9	ificati g phy as the	edic	· ·						
P.O. Box	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
	s that ned b e deta	by Pi	Part II. Other significant conditions contributing to dea	ith but not resulting in the u	inderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	w require been sig should b	Pa	Obesity				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Hunknown
Division of Vital Records,	2 2 2	Completed	(				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiper?			26. Place of Death (			
Ž	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2 ER/Outpatie		4 Unursing Home	e 5 🗌 Residence	6 ☐ Other (Spec	cify)
ū	ding P h. After t funera	ü.	27. Mannerof Death 1 ☐Natural 5 ☐ Pending (Month)	Injury 28b. Time of Injury	Work		d. Describe how in	njury occurred	
sio	Attending in death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			es 2 □No			
Σ	l or Atteno after deatl Director: I in by the	Certification;	determined 286. Place C	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	28	It. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
_	pital ours a eral l		29a. Certifier 1 Certifying Physician: To the b	past of my knowledge, dost	th accurred at the time	o data and place an	ed due to the source	(a)d	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only one)	is of examination and/or in	ivestigation, in my op	inion, death occurred	at the time, date a	and place, and due	to the cause(s)
	roth Mithin Fo the	Me	29b. Signature and title of certifier		29c, License			Date signed (Month	
)	- > F 0		I dela del Ala	Two so	1100	55927	) Ac	court 20	2004
2	2 (-		30. Name and address of person who completed cause	of death (Item, 23a) (Type,	Print)	/	,	0 /	,
1	- (5)		SALVADOR SylvesTer, 3	001 Hospits	al Drive	55927 cheve	orly Me	otry / Am	(4
	Sta			gistrar's Signature			11		
	Registi	ar	AUG 2 5 2004	e & fre	L.				

				State of M							-		•	
			1 - State Registrar				tificate					Reg. No	2001	28421
E	Physicia		1. Decedent's Name (First, Middle, Las Clarence	Dashiell	_						2. Date of Da	i Da	y Yeer 200	3. Time of Death
The second	/Medic Examin	-	4a. Fecility Name (If not institution, give	street and number,	1		4b. City,	Fown, or l	ocation o	of Death	11000		. County of Dea	<u> </u>
	A		P. G. County Hosp				Ch If Under	ever	ly If Under:	04 Usa			rince G	
- 24	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Number 16. Social Security Numbe	ox 7.Ag	ge (in yrs.	7 Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, De Septem	y, Yeer) ber	14,1926	thplece (State or Foreign puntry) Maryland
49	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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	wihin 72 hours after death with the Maryland isene. r than "naturel", or Items 23a or 28a-f show the Medical Examener must be coulded at	Director	10e. Street and Number 2505 Romona Drive				10f. Zip	Code 0747				-	tizen of What Co	-
	leath v	Funeral	11. Marital Status	12. Was Decedent	Ever in U	S. 13. V			panic Orio	gin? (Spe	ecify Yes or No Rican, etc.)		ted Sta	
98	or iter	/ Fun	1 Never Married 2 Married	Armed Forces' 1 ☐¥Yes 2 ☐ If Yes, Give	? No		fYes, <i>s</i> pec 1 ☐ Yes 2		, Mexican Specify:	, Puerto	Rićan, etc.)		Black, Whi	te, etc. Black
9	hours	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		16a. Deced	dent's Usua	I Occupat	ion			16b. K	ind of Business	
215	within 72 ene. than "na	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give life. I	kind of wor DO NOT us	k done du e retired)	iring most	t of workii	ng			nstitute of
d 21	illed w I Hygien other th		Twelth  17. Father's Name (First, Middle, Last)			Print	er		18. Mothe	r's Name	(First, Middle,	Hea		
lan	od all all all all all all all all all al	To Be	Clarence Dashiell								e Mumfo		,	
Maryland 21215-0036	and and		19a. Informant's Name/Relationship (7) Martha Dashiell/W:				-						or Town, State,	Zip Code)
	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition	116	20b. F	lace of Dispo	sition (Nam	e of			shingto		ocation - City or	Town, Slate
<u>E</u>	nit. Pages bertment of iorrant: If it njury or o		1   Burial 2 □ Cremation 3 □  Other (Specify)			emetery, cren ncoln (	Cemete	ery	A		5,2004		-	Maryland
Baltimore,	permit. Pages Department of Important: If if any njury or once.		21. Signature Juneral Service Licen	see ·		16	. Name and	Address	of Facility Iope	y Rob Rd S	ert G. E, Wash	Maso DC	on Fune 20020	ral Home
	14		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	ofications that cause one cause on each I	d the deat	n. Do not ent	er the mode	of dying,	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	a		wint	his	(ca)	aps	2				Minute
в	Examiner			Due to (or as		uence oi):	2	VNO	lun	4				DAY
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	u ce of):								
Ć,	le be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a conseq	uence of):								
3760,	ate be hysicia the bur	100		d			····· <u>·</u>							
x 68	leath certificate attending phys	/Medic	IF FEMALE:	23c. If yes, outcome	of preama	IDCV.								n arrestni.
P.O. Box	0 8 2	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 4 Pregnant a 9 Unknown	2 Feta	death 3	Ectopic pre Other (spe						23d. Date of de Month	Day Year
	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	nderlying ca	luse giver	n in Part I.					the cause of death?
ord	w requir been si should		- Review	1 +		) , , , ;					-			obably 4 Unknown
I Records,	The ate h	Completed	Diabete	3 Ne	以五	Very	4				24a. Was autop perfo 1  Yes		prior to death?	ulopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				. Other			(Check only o		•	
of		7. To	1 ☐ Yes 2 No 27. Manprer of Peath	28a. Date of Inj. (Month, Da		ER/Outpatien 28b. Time of	-	Bc. Injury : Work?	4 🗀 1901		ne 5 🗀 Resid 28d. De <i>s</i> cribe h		6 □Olher (Spe ry occurred	cify)
sion	를 구 등 글	atlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		iy Yeer)	Injury	М		es 2 🗆 î	No				
Division	5 # 15 E	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factory,	office		2	28f. Location (S City or Tox			ural Route Number,
	Hospite 14 hours Funeral tely fille	edical C	29a. Certifier Certifying Ph	ysician: To the best iner: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred a vestigation,	it the time in my opi	o, date and nion, deat	d place, a	and due to the o	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and little of certifier	27	•	>		License	number	65		29d. Dat	te signed (Mont	h, Dey, Year) 19 th 2004
0	0 10		30. Name and address of person who	completed cause of	death (Iten	23a) (Type,	Print)					,,,	Just	11 2004
4	- 0	to	7 2 5 2 31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	r B	ow.	2	Ma	207	25	)	
8.0	Sta Registr		AUG 2 5 2004	State	*	Acen	w .							
DH	MH 17 Rev 1/2	001												

ORIGINAL

			1_ State	partment of Health and Nertificate of Death		0001	20100
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodic or Bouin	2. Date of Death	J. No.	3. Time of Death
	Physicia		Thomasyne B. Dawson		Month August	Day Year 19 2004	9:05 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	, ,	4c. County of Death	
			2330 Gaylord Drive	Suitland			George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry)
	Director		238-70-6318 59 71s.  Usuel Residence of Decedent		July 28,	1945   Nort	th Carolina
	yland		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	e Mar re-f sl	ctor	Maryland Prince George's	Suitland			1 Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hydine. Department of Health and Mentall Hydine. Importent: If tier az is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, it a Madical Examinar must be rudified at once.	I Directo	10e. Street and Number 2330 Gaylord Drive	10f. Zip Code 20746	10g	p. Citizen of What Cou United	•
	r death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	can Indian,
50	rsafte l', or li	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Ame	
3-003b	2 hou atura ical E		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/Ir	ndustry
2	thin 7 e.	Completed	(Specify only highest grade completed) (Giller Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)		0	
7	filed wi Hygien other th			Program Manager		Governm	nent
ana	ntal H ad otl	Be	17. Father's Name (First, Middle, Last)	18. Mothers Nam	e (First, Middle, Ma	100	
Ĕ	hould d Mer mark matic	2	Laird Briggs  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ling Address (Street and Number or Rur	Arvella		n Code)
<u>8</u>	nd 2 s Ith an 27 is i	1 8		611 Regency Park C			,
ē,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dis			c. Location - City or T	
more,	Page: ient o nt: If ry or		1 the bollar 2 Dolernation 3 Differnoval from State		5/2004	Suitland,	MD
Salt	permit. Departm Importe any inju					neral Home	
מ	e e e e		John . Sleway !!!	4001 Benning Rd.			0019
			23a. Part1. Enfer the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition Metastatic bro	east cancer			Onset and Death 13 months
	/Medical Examiner		Due to (or as e consequence of):				
		<u>_</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	ted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
<b>.</b>	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
2/00	cate be executed physician and the burial-transit	dicai	d				
٥	certificate Iding phys		IF FEMALE:				
X Q Q	death certifica e attending ph ed for use as ti	ician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death	□Ectopic pregnancy		23d. Date of deliver	ery Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
Ţ.	that the ed by detac	Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ds,	v requires that the d been signed by the should be detached	d by			1 ☐ Yes	2∏No 3□Prob	oably 4 Unknown
Cord		lete			24a. Was an	24b. Were auto	ppsy findings available
r	0 5 0	ompleted			autopsy performe	d? death?	ppsy findings available impletion of cause of
	iician: Th certificate rector, pag	C	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)	No 1	2   NO
	Physician: r this certific ral director.	ToB	exeminer? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 🙀 Residenc	ce 6 □Other (Specif	(y)
n or	ding Pt h. After th funeral		27. Manner of Death 1 ဩrNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how	injury occurred	
VISION	r Attendi er death. rector: A by the fu	cati	2 Accident investigation	M 1 Tyes 2 No	00/ 1 (0)		
<u> </u>	after of after of Direct of in by	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, factory, office	City or Town, S	et and Number or Rura State)	al Houte Number,
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier  (Check only one)  1   Certifying Physicien: To the best of my knowledge, de 2   Medicel Exeminer: On the basis of examination and/or and manner stated.				
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
			Jem Thamon My	D53829		August 23	, 2004
ρ.	0-15		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	eenway Center Dr.,	#205, Gre	eenbelt, M	0 20770
	Registr		AUG 2 5 2004 Keete & Son	R)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** 2004 8:07Am 08 20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPICE ATTHE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 100m100 CASTAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 6. Sex Sex 1 ☑ M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Days 2 IH-36-5996 Director 09/19/1940 MARYLAND Usual Residence of Decedent permit. Pages 1 end 2 should be filled within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or harmone eny injury or other treument. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Parsonsburg 101. Zip Code Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? 21849 Funeral 7635 Lovy Lane USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💆 No Specify: Specify: ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ W. Ennis George Beatrice Beam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7635 Lovy Lane, Parsonsburg, Maryland 21849

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, Sta (wife) Barbara Jean Ennis 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Salisbury Crematory August 23, 2004 Salisbury, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association Cerle 501 Snow Hill Road, Salisbury, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 25 No 25 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 □ Yes X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA : After this tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours efter death.

To the Funerel Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Soluty NID 21802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Couts LL

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

AUG 23

2004

32. Registrar's Signature

6	E	/ler for 1 - State Registrar	State of Maryla	_	artment of <i>rtificate of</i>		ental Hygie _{Reg.}	2006	28424
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
Physicia /Medic			JENNIFER ANN	1 EYLE	3			Day Ye 22 200	
Examin		4a. Facility Name (If not institution,				or Location of Death		4c. County of D	
		Carroll Hospita	al Center		Most	minator		Carro.	1.1
Funeral			6. Sex 7. Age (In yr	s. last birthday)	If Under 1 Year	minster If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreig Country)
Director		214-66-5181	1□M 2 <del>/</del> √F 4	. 9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 10/12/1	954 N	IARYLAND
		Usual Residence of Decedent							
shoy	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limit
r 28a-f show	cto	MD. CARR	(OPP .1	'ANEYT(	)WN				1 ☐ Yes ¾☐ N
or 2	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
ust t	a	3124 BLACKS	SCHOOLHOUSE	RD.	217	87		USA	
ELD!	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto F	cify Yes or No-		merican Indian, /hite, etc.
- File	F	1 Never Married 2 Marrie			1 ☐ Yes 2 💆 No		noari, etc.)		
EX	d by	3 Widowed 4 Divorced	Year or Dates:		10165 223110	зр <del>в</del> сну.		Specify: W	HITE
disal Ex	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occu	pation	16b	. Kind of Busine	ss/Industry
N N	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		during most of working ad)	į		
other traumatic event, the M	Con	12			RECEP'	TIONIST	AN	IMAL C	LINIC
Vent	Be (	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	(First, Middle, Maid	len Sumame)	
2	To	K	ENNETH W. WI	NGATE		ANN A.	ALLEN		
emu		19a. Informant's Name/Relationship	p (Type, Print)	19b. Maili	ng Address (Stree	t and Number or Rural	Route Number, Cit	y or Town, State	e, Zip Code 21787
any injury or other tra once.		WILLIAM H. EY	LER -HUSBAND	B124	BLACKS	SCHOOLHO	מס שפוונ	መ እ ነው እ	
ᄚ		20a. Method of Disposition	20b.	. Place of Dispo	sition (Name of	Da		Location - City	
ě		1 Burial 2X Cremation 3	Removal from State	cemetery, crei	natory or other pla	ATION 8/			
		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service □</li> </ul>							
ouce		21. Signature of Funeral Service Li	O INSEE			ess of Facility FL]			
		23a. Part1. Enter the disease, or co	may see					STER, N	MD. 21157
ne bu	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection	equence of):	de seulos	usmi			Onset and Death
	Med	IF FEMALE:							
	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 🇷 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o	delivery Day Year
	P /	Part II. Other significant conditions	s contributing to death but not re	sulting in the u	nderlying cause on	ven in Part I.	23e. Did tobacci	o use contribute	to the cause of death?
	d by				, , ,				Probably 4 □Unknown
pinous	ete						1.2,100		
7 9	Completed						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
	0						performed?		? es 2 ☐ No
		25. Was case referred to medical examiner?				26. Place of Death	Check only one)		
	a		Hospital: 1   Inpatient 25	ER/Outpatien	t 3 DOA Ott	her: 4 Nursing Hom	e 5 Residence	6 ☐Other (St	pecify)
	Be	1 TyYes 2 □ No	28a Date of Injuny	28b. Time of	28c. Inju	ry at 28	d. Describe how in		,,
	To Be	27. Manner of Death	Adopth Charles	Injury	M 1	rk? ]Yes 2 □No			
	To Be	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	,,			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
ineral director,	To Be	27. Manner of Death  1 Natural 5 □ Pending	t be	home, farm, str		28	3f. Location (Street: City or Town, Sta	and Number or ate)	Rural Route Number,
ineral director.	Certification; To Be	27. Manner of Death  1. Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying	t be 28e. Place of Injury - At	home, farm, stroify)	eet, factory, office	me date and place, ar	City or Town, Sta	(s) and manner	as stated
	To Be	27. Manner of Death  12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only) 2 Medical Ex	28e. Place of Injury - At l building, etc. (Spec Physician: To the best of my kr taminer: On the basis of examin	home, farm, stroify)	eet, factory, office	me, date and place, ar opinion, death occurred	City or Town, Stand due to the caused at the time, date a	(s) and manner	as stated. ue to the cause(s)
ineral director.	Certification; To Be	27. Manner of Death  12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigat 6 Could not determine	28e. Place of Injury - At l building, etc. (Spec Physician: To the best of my kr taminer: On the basis of examin	home, farm, stroify)	eet, factory, office a occurred at the ti restigation, in my o	me, date and place, ar opinion, death occurred se number	city or Town, Stand due to the caused at the time, date a	(s) and manner nd place, and d	as stated. ue to the cause(s) nth, Day, Year)
completely filled in by the funeral director.	Certification; To Be	27. Manner of Death  12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier   Jown	ton t be ad  28e. Place of Injury - At building, etc. (Spec Physician: To the best of my kr caminer: On the basis of examin and manner stated.	home, farm, straity)  nowledge, death hation and/or inv	eet, factory, office  a occurred at the ti restigation, in my o	me, date and place, ar opinion, death occurred	city or Town, Stand due to the caused at the time, date a	(s) and manner nd place, and d	as stated. ue to the cause(s) nth, Day, Year)
al Director: After this o	Certification; To Be	27. Manner of Death  12 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigat 6 Could not determine	ton t be ad  28e. Place of Injury - At building, etc. (Spec Physician: To the best of my kr caminer: On the basis of examin and manner stated.	home, farm, straity)  nowledge, death hation and/or inv	eet, factory, office coccurred at the ti restigation, in my coccurred 29c. Licens	me, date and place, ar opinion, death occurred se number	d due to the caused at the time, date a	(s) and manner nd place, and do cate signed (Mo	as stated. ue to the cause(s)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State	i maryiar		tificate		eaith and r D <i>eath</i>	ленан пу	Reg. No.	01. 2	01.25
			1. Decedent's Name (First, Midd	lle, Last)						2. Date of De	- / / :	Year 3.	Time of Death
	Physici /Media		Allen Clark F	Edgar						August	•		2:15 PM
	Examir	_	4a Facility Name (If not institution	on, give street and nu	mber)			4	b. City, Town, or L	ocation of Deat	h 4c. County		
	Funeral		11886 National 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		Grantsv If Under 24 Hrs. Hours Min.	8. Date of Bi		9. Birthplace	State or Foreign
	Director		215-36-9182	1 <b>2</b> M 2□ F	66	Yrs.	MOINTS	Days	TIOUIS IVIII.		1937	Marylar	
	P .		Usual Residence of Decedent		10- 0	ity, Town or Lo					<u> </u>	-	side City Limits
	arylan		10a. State 10b. County	<b>/</b>	10c. C	•							Yes 2 No
	the M	Director	Maryland Garre	ett		Grant					40 000 (1		
	P Q K	吉	10e. Street and Number				10f. Zip		21526		10g. Citizen of \	What Country?	
	234 n	<u>a</u>	11886 National		adant Cuasia I	10 121	Man Done		21536	posifu Voe or N	USA 14 Bac	e - American Inc	dian
20	within 72 hours after deeth with the Maryland ene. than "naturel", or itema 23a or 28a-f ahow he Madicel Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2\(\tilde{\Omega}\)Ma: 3 □ Widowed 4 □ Divorce	Armed Fo	edent Ever in Lorces?  2 No ve Vietr pates:	nam	f Yes, spec 1 ☐ Yes 2		ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Blac	ck, Whita, etc.	
Ş	Tural Pour	象		nt's Education	Wa	120	lent's Usua	al Occune	etion		16b. Kind of B	usiness/Industry	
Maryland 21215-0020	In 72	Completed	(Specify only highe	est grade completed)	4.45.3	(Give	kind of wor DO NOT us	rk done d se retired	etion during most of world)	king		,	
212		E	Elementary/Secondary (0-12)	College (	1-40r 5+)	Maint	enace	Wor	ker		Retail	Store	
D	be filed ntel Hygk od other event,	Be C	17. Father's Name (First, Middle	, Last)					18. Mother's Nam	e (First, Middle	, Maiden Suman	ne)	
lan	should be nd Mentei marked o	To B	William Donald	d Edgar					Dora El	izabeth	Kahl		
ary	d 2 should I th end Meni 7 le marked treumatic		19a. Informant's Name/Relation			19b. Mailin	ng Address	(Street a	and Number or Ru	rai Route Numb	er, City or Town,	State, Zip Code	9)
			Mary A. Edgar/	ui fo		1188	6 Nat	iona	l Pike.	Grantsv	ille, M	21536	5
ē,	of Haalth Item 27 I		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer	sition (Nan	ne of ther plac	e)	Date 2004	20c. Location -	City or Town, S	tate
ě	90-2		1/2/Burial 2 Cremation 4 Donation 5 Other (		State	antsvil			ery A	ug.28,	Grantsvi	ille. MI	)
Baltimore,	Department Department Important: I eny Injury c	1	21. Signature of Funeral Service					_	ss of Facility Homeral Home	- D A	GEGIICOV.	LIIC/ III	
å	Depa Impo eny li		I De Su	Jee	men	P حر	.O. B	30x 2	75; Gran	tsville	, Maryla		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that only one cause on o	caused the dea each line.	th. Do not ent	er the mod	e of dyin	g, such as cardiac	or respiratory a	arrest,		oximate val Between et and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. 4	ng oye to (	Cay or as a consec	CC: quence of):	~	>			 	
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	icata be executed physician and s the burial-transit	Examiner	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate									į	
68760,	iclan buria	<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   Due to (or as a consequence of):  c								-		
387	ficata phys s the	edical	resulting in death) Last  Due to (or es a consequence of):								!		
	ding			d									
Box	eath cert ettending	ciar				- 101 - 1 - 10			en in Deut I	22h Did	tobacco use co	ntribute to the	nause of death?
P.O.	res that the de signed by the e I be datached f	ysi	Part II. Other significant conditi	ions contributing to d	eath but not re	sulting in the u	ndenying c	ause give	en in Parti.		Yes 2□ No		
	ed by data	=								,,,	Tes 2LINO	3 I Flobably	4 DOMINIONII
Division of Vital Records,	been should	Completed by Physician/M								24a. Was	an autopsy ormed?	available	ion of cause
æ	The lay ate has page 2	E								10	Yes 2 No	1 □ Yes	2 No
tal		Bec	25. Was case referred to medical	al					26. Place of Dea	th (Check only	one)		
≥	yalch is cer direc	10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	OA Oth	er: 4 Nursing H	ome 5 Res	idence 6 □Oth	er (Specify)	
ō	er th		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury	2	8c. Injun	y at k?	28d. Describe	how injury occur	red	
<u>o</u>	ath. r: After ne funer	ま	Z LI AUCIUGIII	tigation	, , ,	,.,	М	1 🗆	Yes 2□No				
<u>&lt;</u>	ar de	\$	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	of Injury - At h	nome, farm, sti	eet, factory	y, office		28f. Location ( City or To	(Street and Numb wn, State)	oer or Rural Rou	te Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical Certification:	(Check only 2 Medica	ng Physician: To the Examiner: On the b	asis of examin	owledge, death ation and/or in	occurred vestigation,	at the tim , in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as stated. and due to the	cause(s)
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	04/1/		30. Name and address of person	11 000	se of death (Ite		Print)	6	34231 Gran	tensila	no h	>>	,
	W		31. Date filed (Month, Day, Year	1	Registrar's Sign		let St	+	w an	120111E	, IND	2153	6
	Sta Registi			7 2004	Andreas a	M A	Conto.	D					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 18 04 08 08:15 A M Frederick Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Laurel Regional Hospital LAure1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1**⊠** M 2□ F Director Yrs. 579-22-2073 80 03 30 24 Washington, D.C Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner wast be notified at 10d. Inside City Limits D.C. 1.☐Yes 2☐No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1526 Varnum Street N.W. Completed by Funeral 20011 filed within 72 hours after death **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 Is marked other than "natur other traumatic event, Ir a Modical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Messenger U.S. Government 4th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel Edwards ျှ Mary Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Rushie Croxton/Sister 1526 Varrium St. J.W. Washington, D.C. 20011 Date of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln 8-23-04 * 4 □ Donation 5 □ Other (Specify) Brentwood, MD. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 mauhall 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Annrovimate Interval Between Onset and Death Immediate Cause (Final Firysician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events Decubitus Ulcer resulting in death) Last Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Cerebro Vascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s Atrial Fibrilation autopsy performed? certificate 2 🔀 No Diabetes Mellitus
25. Was case referred to medical examiner? 1 Yes To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year)

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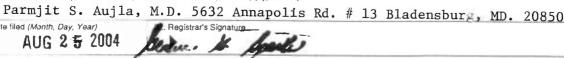
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State Registrar

31. Date filed (Month, Day, Year) AUG 25 2004

Spey'l MD. Altendias.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D 42580

8-19-04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Paulina Espinoza 9:45A August 24. 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Springbrook Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 74 Months 1 ☐ M 21 F 579-76-9260 June 8, Director 1930 Peru Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County or 28e-f ehov Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla nent of Health and Mental Hyglene.
shir: If Hean 27 Is marked other then "natural", or Items 23s or 28e-f ehow and the returnatic event, its Maricia Examination at De notified at Maryland Montgomery Silver Spring 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 University Blvd. E 20903 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠Yes 2□No Specify: Peruvian Specify: Spanish 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Josefina Torres 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsa Martinez/Niece 11004 Haven Park Drive; Silver Spring, MD. 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
eny injury or ot
onge. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. Aug. 26, 2004 Silver Spring, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes; 11315 Lockwood Dr. Silver Spring, MD: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20904 2 23a. Part1. Enter the alsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Sepsis weeks resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pneumonia 7 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transil that initiated events and resulting in death) Last Due to (or as a consequence of): attending physicien Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 XNo 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe End Stage REnal Disease 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? Multi organ failure 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 19609 van August 24, 2004

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			1 - For State Registrar	State of Ma	•		nt of He		nd Menta		ene 1. N2. 0. 0. 4	28428
			1. Decedent's Name (First, Middle, La							te of Death		3. Time of Death
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ì	/Medic Examin		4a. Fecility Name (If not institution, gir			4b. City	Town, or Lo	ocation of I		9000	4c. County of Dear	
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	Funeral		5. Social Security Number   6.	Sex 7. Age 1X M 2□F	(In yrs. last birthda	y) If Unde Months			Hrs. 8. Da Min. (Mi	te of Birth onth, Day, Y	(ear) 9. Bird	hplace (State or Foreign
×	Director		212-16-7503	IZIM ZUF	90 Yrs.				Man	ch 19,		yland
	and *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Aaryl r •ho	ō			G-14-1							1 √Yes 2 No
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ω.	or Ita		1 Never Married 2 Married	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give	Army 1942-				Puerto Rican,	etc.)	Black, Whit	e, etc.
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and	a la b	Be	17. Father's Name (First, Middle, Las				18				aiden Sumame)	
Z Z	d 2 should be the and Menta 7 is marked traumatic even	10	John Carl  19a. Informant's Name/Relationship	Flemi		ilina Addres	e (Street and	Mari		Oliv	City or Town, State, 2	Mills
Maryland	h ar				1							
e,	1 ar Hea Hea the		Dr. Bruce E. Fle 20a. Method of Disposition	ming (son)	20b. Place of Dis	position (Na	me of	ge roa	Date		le, Maryland Oc. Location - City or	
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	/Medical		resulting in death)	d.	consequence of):	4700						
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	₽ #	ner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	. 4						
	ecute and trans	Examiner	that initiated events resulting in death) Last	0.	1 ENT	1 11-						
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Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t		B⊟Ectopic p					Month	Day Year
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۹.	\$ 99 B	by PI	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying	cause given	in Part I.	23	3e. Did toba	cco use contribute to	the cause of death?
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Vital Records,	0 4 0	Completed							10	autopsy performe ☐ Yes 20	d? death?	completion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				2	6. Place of	t Death (Chec			
of V	N N	To	1 Yes 2 No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpat	ent 3 D	OA Other:	Nursi	ing Home 5	Residen	ce 6 □Other (Spe	cify)
	ding Ph h. After th funeral		27. Manner of Death  N 2 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time		28c. Injury a Work?			escribe how	injury occurred	
sio		cati	2 Accident investigate 3 Suicide 6 Could not	20		М		s 2 No				
Division	- 0 -	Certification:	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, . (Specify)	street, factor	y, office		28t. Lo	cation (Stre ty or Town, .	et and Number or Ru State)	iral Route Number,
	Hospital 4 hours a Funeral D fely filled		29a. Certifier 1 Certifying P	husioism. To the boot o	f my knowloden da	eth converse	l at the time	data and a	alass and du		(-)	atolod .
	he Hospital o n 24 hours aft he Funeral Di pletely filled in	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/or	investigation	n, in my opin	ion, death	occurred at the	e to the cau ne time, date	se(s) and manner as and place, and due	to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier			29	c. License n	number		290	d. Date signed (Mont	h, Day, Year)
	- s - 0		1 30.	M.D.			D57	95	2	7.	August 17,	2004
W	Jan .		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print)		15.55		P	uqust 1/,	2004
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	Sta		31. Date filed (Month, Day, Year) AUG 18	2004 32. Registra	r's Signature	9 1	book	1				
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Registrar

Box 68760 Records, P.O. Division of Vital To the Hospital or Attanding Physician: death. after death | Diractor: , d in by the f within 24 hours a To the Funaral I

e and title of certifier 29b. Signati NG

4 Homicide

(Check ont) one)

29a. Certifier

29c. License number O.C.M.e

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) AUG. 26, 2004

Year

Рм

completed cause of death (Item 23a) (Type, Print) 30. Name

and manner stated

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day AUGUST 7, **Physician** Miller Frazier, Jr. 2004 4:24 A N /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CO PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 8, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Hours **₩**M 2□ F Days 64 250-64-6748 Director South Camilina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28e-f show treumatic event, the Medical Examiner must be notified at Temple Hills Prince George's Maryland 1XXYes 2 □ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 2405 Southern Avenue #B-5 U.S.A. "natural", or Items 23e 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∕2√Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 in and Mental Hygiene. 7 is marked other then "ne Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/A 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miller Frazier, Sr. Fannie Swanson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: if item 27 is rr eny injury or other treum once. 1401 Fairmont Street, N.W. Apt. #414 Washington, D.C. Mrs. Lillian L. Frazier (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Chesapeake Crematory, Inc. August 24,2004 Beltsville, Maryland `4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Rollins Fuheral Home, INc. 4339 Hunt Place, N.E. Washington, D.C. 20019 of. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HUMPUS IM Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 2XX €R/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Attending 5 Pending investigation 1 Dyaturai 1 ☐ Yes 2 ☐ No BEDESTRIAN STRUM BY VEHICLE death. LNK Hospitel or Attendi 24 hours after death. Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide ROPOWA 400BLK SOUTHSAN AVE WASHINGTON 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signafure and title of certifier 29c. License number 2

State

Missim 31. Date filed (Month, Day, Year) AUG 2 5 2004

Minte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LORD Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

OCME

AUGUST 8, 2004

		1 - State RegistrarAMEND TTEM #  1. Decedent's Name (First, Middle, Last,	State of Maryland / Dep. 29d PER PHY C836 CT		Reg. N	000					
hysici/ Medic/		WILLIAM LEE GRI	FFIN		8 20	2004 02502					
Examin	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1	c. County of Death					
, novel		5135 Double Bri 5. Social Security Number 6. Sec		Snow Hill If Under 1 Year   If Under 24 Hrs.		Worcester					
uneral rector			M 2□F 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 5/21/19	9. Birthplace (State or Fore					
Mo III		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lin					
filed filed	tor	MD Worceste	r Snow Hil	11		1 Tes 2					
or 28 e nai	Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?					
23a ust b	ral	5135 Double Bri		21863	USA						
important: If tem 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other treumatic event, the Medical Exal-directment be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married ②☐Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (S _i If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black					
etura ical E		15. Decedent's Edu	cation 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry					
M. da	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	king						
유명 :	Con	12	2 FOOD	SERVICE SUPERV		15 HIR FORCE					
even	Be	17. Father's Name (First, Middle, Last)	0 1	18. Mother's Nam	e (First, Middle, Maide						
nark natic	2	19a. Informant's Name/Relationsh (Tv.	GRIFFIN	EVA (	JUNTHER	? GRIFFIN					
7 is r treur		^	N~WIFE 5/35.	ng Address (Street and Number or Ru	C . 1	or Town, State, Zip Code)					
tem 2 other		20a. Method of Disposition	20b, Place of Dispo	LINIBLE BEIDGE KL		Location - City or Town, State					
nt: #f		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State    Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Cometery, crem   Co	natory or other place)	1						
important: If any injury or once.		21. Signal se Fu le al Service Openso		METARY 8/3 2. Name and Address of Facility B	EADOLE 5	SMITH FIH					
any ir		MIXLIST	24/1	1711 TSABELLA		SBURY, MD, 2180					
		23a. Part1. Exter the disease, of compli	cations that caused the death. Do not ent e cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest.	Approximate Interval Between					
sician		Immediate Cause (Final disease or condition	Cat >			Onset and Death					
edical miner		resulting in death)	Due to (or as a consequence of):			SEVEZAL YX					
*	L	Sequentially list conditions, b									
ısıt	nine	Sequentially list conditions, If any leading to it move alle cause. Enter Underlying Cause (Disease or injury									
physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
siciar a buri	dlcai E										
g phy as the	O.										
been signed by the attending p should be detached for use as	Physician/M	200. Was decedent pregnant	3c. If yes, outcome of pregnancy	7°		23d. Date of delivery					
ne att	sicia	in the past 12 months? 1 \(\sumsymbol{\text{Ves}}\) 2 \(\sumsymbol{\text{No}}\)	4☐Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		Month Day Year					
by the	hys	9 🗆 Unknown	9□ Unknown	22 240							
igned be de	by	Part II. Other significant conditions con	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of							
S uee	ted	MSCVD,	PROSTATE CH		1 Tes 2	2 No 3 Probably 4 Minkno					
2 5	Completed				24a. Was an autopsy	24b. Were autopsy findings availal prior to completion of cause of					
certificate has rector, page 2	Con				performed? 1 ☐ Yes 2 🔼 N	death?					
is certificate ha	Be	25. Was case referred to medical examiner?	ospital:		h Check only one						
al di	. To	1 No 27. Manner of Death	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury 28b. Time of		me 5 Residence						
ector: After th by the funeral	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred					
y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		296 Location (Street and Mumber of Duni On to Mumber						
d ri b	erti	4 Homicide determined	City or Town, Stat	ocation (Street and Number or Rural Route Number, City or Town, State)							
Funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medicel Examin	ician: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(sed at the time, date an	s) and manner as stated. Id place, and due to the cause(s)					
0 0	Me	29b. Signature and title of certifier		29c, License number	29d. Da	ate signed (Month, Day, Year)					
ro the		1 million	Holyout, M. S.	D 06241	2	20 000					
To the Funeral Director: After completely filled in by the funer		soulthis co	no your , mier	200-11	42	200					
To the complet			npleted cause of death (Item 23a) (Type, I HOLZINORTH, IV		-8/	20/2004					

DHMH 17 Rev 1/2001

10350 hrs 8/30/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2:08 PM **Physician** James Hamilton Geisbert, Jr. 2004 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 305 East Third Street Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) Apr 21 1954 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 152 M 2□ F Director 215-64-0830 50 Brunswick MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ent: If item 27 Is marked other than "natural", or Itema 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or itema 23a or 28a-f show Examiner must be notified at MD Frederick Frederick 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 305 East Third Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: 3 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Hamilton Geisbert, Sr. Gloria Shrader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas E. Best, Uncle 5763 Woodglade Circle, New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Park Heights Cemetery 8/21/2004 4 ☐ Donation 5 ☐ Other (Specify) Brunswick, MD 21. Signalizaçõe Fingal Savice Ligassee VIII (Un Barbara A. Williams, Owner 22. Name and Address of Facility John T. Williams Funeral Home Brunswick, MD 21716 Approximate Interval Between Onset and Death

Physician /Medical Examiner

physician

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After

Diractor:

within 24 hours a To the Funaral L

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Baltimore, Maryland 21215-0036

the 99 page 2

3

Completed

Be

2

Certification:

Medicai

the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

		100 TELETSVILLE ROAD, DIG	HOWLL
	23a. Part1. Enter the disease, or of shock, or heart failure. List of		
	Immediate Cause (Final disease or condition resulting in death)	a. Arterioscleratic Cardiovascula S	Dises
icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	
nysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Inpatient

23e. Did tobacco use contribute to the cause of death?

Month

1 Probably 4 ☐ Unknown

Date of delivery

24a. Was an autopsy 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

leaus

Year

Other:	4 Nursing H	ome	5 Residence	6	Other	(Specify)
jury at		28d.	Describe how inju	гу	occurred	

28c. Injury a Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3□ DOA

Name and address of person who completed cause of death (Item 23a) (Type, Print) ZARICK JA

Hospital:

5 Pending investigation

6 Could not be

determined

Frederick, MD 21701

State Registrar 31. Date filed (Month, Day, Year)

morew

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

4 - Homicide

☐ Accident

AUG 2 0 2004

32. Registrar's Signature

2 ER/Outpatient

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Vaar **Physician** JULIA KATHARINE GOUGH **AUGUST** 7:10P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13 TADCASTER CIRCLE WALDORF CHARLES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 94 Director 215-52-6248 MAY 22,1910 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Itam 27 Ia marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director MD CHARLES WALDORF 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 4295 RENNER ROAD 20602 S. Α. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE AT HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATE EMMA LYON HENRY CLARENCE THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 Ian any injury or othar traun MARY KAY ESTEP / DAUGHTER 7625 ESTEP PLACE CHARLOTTE HALL, MARYLAND 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 30. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) TRINITY MEM. GRDNS. 2004 WALDORF, MARYLAND 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. 21. Signatore of Funeral Service License BE 30195 THREE NOTCH RD CHARLOTTE HALL, MD 20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No ö 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Ponknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 2 No 1 Yes Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 __Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Xother} \) (Specify) \( \text{ASS}^T \) \( \text{LIVN} \) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 40001009 8-26-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRY L. 115 LA GRANGE AVENUE LA PLATA, MARYLAND 20646 BURKE, M.D. 32. Redistrar's Signature 31. Date filed (Month State Registrar

			For State	State of Ma	aryland		rtment of H		nd Mental		2006	28435
	Physici	an	Registrar  1. Decedent's Name (First, Middle, L	ast)		001	uncate of i	Jean	2. Date Mon	of Death th	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g	o In W9			4b. City, Town, or	r Location of	f Death	5	4c. County of Dea	1 0014 M
	Examin	er	Hound County	General	Ab (	ortal	Calu	2614	•		House	al
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 2		of Birth	9. Bir	thplace (State or Foreign puntry)
	Director		216-40-0084	^{1□ M 2√2F} 62	2	Yrs.				<del>-</del> 1942		ryland
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary f sho	ţō	MD Howard		FII	icott	City					1 □ Yes 2√2 No
	h the	Director	10e. Street and Number				10f. Žip Code		· <u> </u>	10g.	Citizen of What Co	ountry?
	238 c	alD	9565 Joey Drive				21042			Un	ited Sta	
	tems terms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		i. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Orig n, Mexican,	in? (Specify Yes , Puerto Rican, e	or No- tc.)	14. Race - Ame Black, Whit	
36	thin 72 hours after death with the Maryland e. an "natural", or Items 23s or 28s-f show Medical Examinat must be multified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10		1 ☐ Yes 2 ☑ No	Specify:			Specify: W	hite
21215-0036	72 hou natura dical E	ted	15. Decedent's	Education		16a. Deced	ient's Usual Occupa	ation	of dela =	16b	. Kind of Business	/Industry
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and	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, La Lester Hull	St)							ien Sumame)	
Maryland	d 2 should th and Men 7 is marke traumatic	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street		ula Zepp r or Rural Route		ty or Town, State,	Zip Code)
	1 and 2 thealth ar tem 27 is		Stan Glinka/Husba	and		9565	Joey Dri	ve El	licott C	ity,	MD 21042	
J.	S		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	□ Pomoval from State	20b. Pla	ace of Dispo	sition (Name of natory or other plac	ce)	Date	200	. Location - City or	Town, State
Ë	nit. Pages partment of l ortant: If its injury or of		'4 □ Donation 5 □ Other (Spe				n Memoria				rriotsvi	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lin	ensee	mol							mily FH, Inc. , MD 21043
			23a. Part1. Enter the disease, or co	emplications that caused	the death.						OLL CILV	Approximate Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	T Colo 2	hall	C	Mar sales	214	lus			Onset and Death
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89		Med	IF FEMALE:									
Вох	death certifica e attending ph ed for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy	,			23d. Date of de Month	livery Day Year
0.	0 0 2	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time or de	am 5L	Other (specify)					
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rds	quíres en sig	ed b	Instans 1	indrone						1 🗌 Yes	2 No 3 ₽	robably 4 Unknown
Record	ne law requ has been ge 2 shouk	Completed	Dilated Co	dio my of 4	they				24a	. Was an autopsy	prior to	utopsy findings available completion of cause of
H		Соп		/ /					1 🗆	performed Yes 2 🗔		2 □ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	05	of Death (Check			
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on	Attending For death.  ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investiga		ý Year)	Injury		k? Yes 2 □1	No			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of Inju- building, etc	ury - At hor	me, farm, str	reet, factory, office			ation (Stree or Town, S		ural Route Number,
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2	20		30. Name and address of person wi		leath (Item	23a) (Туре, 5 7	Print)	11/1	20 a Coh	1	0-1-	
Y		ate	31. Date filed (Month, Day, Year)	10/15 M	O ≠ ar's Signat	ure	23 60		7 00/4	Nois	and a	21077.
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			For State Registrar	State of M	<b>1</b> arylar		artment o			nd Mental	Hygien	nol.	28436	
	Physici /Medic		1. Decedent's Name (First, Middle, RUTH MARIE	•						2. Date Mont	of Death h Da		1/ 1/4	
	Examir			nas Medie	of Co	enter last birthday)	4b. City, To	US	buse Under 24	1		County of De	nico	
	Funeral Director		216-38-9876 Usual Residence of Decedent	1□M 2 <b>X</b> F	64	Yrs.				Min. (Mon:	th, Day, Year 30/193		Birthplace (State or Fore Country)  MD	aign
	show	7	10a. State 10b. County  MD Worce	eter	10c. Ci	ty, Town or Lo	cation letree						10d. Inside City Lim 1 ☐ Yes 2X	
	the M	Director	10e. Street and Number			- Gira	10f. Zip Co	ode			10g. C	itizen of What		
	th with	ai D	5801 Onley	RD			2	1829				USA		
036	be filed within 72 hours after death with the Maryland hal Hyglene. od other than "natural", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Deceden Armed Forces od 1 Tyes 2 1 1 Tyes 2 1 1 Yes, Give Year or Dates:	? <b>(</b> No		Was Decedent f Yes, specify 1 ☐ Yes 2 ☐		anic Origin Mexican, F Specify:	n? (Specify Yes ⊇uerto Rican, et	or No- c.)	14. Race - Ar Black, W Specify: V		
21215-0036	within 72 ho ene. than "natu he Mevical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	(Give life. l	tent's Usual C kind of work of DO NOT use i	done durii retired)	ing most o	f working		Kind of Busine		
	Hygie other	Be Co	11 17. Father's Name (First, Middle, L.	ast)		La	b Tecl			Name (First, M		Canner	-у	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, Ira Mar	To B	Joshua Andre	ews.					Lou	iise Mer	ritt			_
Mar	s 1 and 2 should f Health and Mer ftem 27 is marke other traumatic		19a. Informant's Name/Relationshi							or Rural Route N				
	ges 1 and 2 t of Health If item 27 I or other tra		Terry Lambo			Place of Dispo cemetery, cren	sition (Name	of	KD.	Stocktoi Date	-	21864 ocation - City	or Town, State	
imo	Pages nent of ent: If it		Yurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State ecify)	∍	oringhi	•		y	27/04	Gir	dletre	e, MD	
Baltimore,	permil. Pages 1 Department of F Importent: If ite any injury or ot		21. Signature of Feneral Service Li	Burbal	_		208 W.	rec	<u>aerai</u>	Burbage St. Sn	OW HII	ral Hom	ne 21863	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that sause nly one cause on each	ed the deat line.	th. Do not ent	er the mode o	forlying, s	such as ca	rdiac or respirat	ory arrest,		Approximate Interval Between Onset and Death	
	Physician / /Medical		disease or condition resulting in death)	aDue to (or a	a consec	Tuence of):							ILA	_
B	Examiner		Sequentially list conditions	b e	nc	epha	len	ch	Ky	,			16h	
	be sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	s a consec	quence of):	,		/				21110	
8760,	tate be executed obysician and the burial-transit	dicai Examin	that initiated events resulting in death) Last	c. Due /(or as	s a conseq	quence of):  ML	Car.	C.					1 We 24s	)
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 honths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3	Ectopic pregr Other (s <i>peci</i>					23d. Date of d Month	lelivery Day Year	
Δ.	equires that an signed b	by	Part II. Other significant condition	s contributing to death	but not res	sulting in the ur	nderlying caus	se given ir	n Part I.		Did tobacco		to the cause of death?  Probably 4 Unknown	
Vital Records,		Completed	· · · · · · · · · · · · · · · · · · ·							_	Was an autopsy performed (es 2/2/No	prior to death		ble of
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	iont 2	LEB/Outpation	2 004	Other		Death (Check		a = 0.1		
ion of	Te Te	1	27. Manner of Peath  1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, D	urv	ER/Outpatien 28b. Time of Injury		Injury at Work?	4 □ Nursii 2 □ No		Residence ribe how inju		oecify)	
Division	in Dir	Certification:	3 Suicide 6 Could no determin	ed   286. Place of Ir	njury - At h	ome, farm, stre	eet, factory, or	ffice		28f. Locat City o	ion (Street ar or Town, State	nd Number or i	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	Physicien: To the bes xaminer: On the basis and manner s	of examina	owledge, death ation and/or inv	estigation, in	my opinio	on, death	place, and due to occurred at the t	the cause(s time, date and	) and manner and du	as stated. ue to the cause(s)	
	To T	Σ	29b. Signature and title of certifier				29c. Li	icense nu	ımber	2 -	29d. Da	te signed (Moi	nth, Day, Year)	
•			30. Name and address of person w	to completed cause of	death /lter	n 23a) (Tune	Print)	100	6/	327	10	1201	04	
1.1	1,3		Elled Zieme	104 M	1 ford	St. SAI	isbury	md, E	2180	(				
	Sta Registr		31. Date filed (Month/Day, Year)  AUG 2	104 Mi 32. Regist 4 2004	trar's Signa	the A	barle							

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29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  8/2//04  30. Name and address of operson who completed cause of death (Item 23a) (Type, Print)  Hung Davis, M.D., 2001 Medical Pkwy., Annapolis, MD 21401  State  31. Date filed (Month, Day, Year)  32. Registra Signature		olta urs aral			8								
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State Registrar  AUG 2 4 2004		X		Hung Davis, M.D.,			, Annapol	is, MD 2	21407				
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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19a peratehofa 35/land 450 partnent of Health and Mental Hygiene 1- Registrar Amend item 21 per dvr g835 9- 8-01 licate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 30 Month John Edwin Hayden 2004 8:51 August а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3823 Aldino Road Aberdeen Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 10/27/46 **Funeral**  Birthplace (State or Foreign Country)
 Ohio Months MM 2 F 296-46-4719 Director 57 Vrs Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location 28a-f show 10d. Inside City Limits raumatic evant, the Madical Examiner must be notified at MD Harford Aberdeen Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3823 Aldino Road 21001 U.S.A. or Itams 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Never Married 2 Married 1 XYes 2 No If Yes, Give Year or DatesVietnam 1 Yes 2 No ð Specify: White 3 Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service 4+2U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If itam 27 is marked of Rodney Hayden Marie Haxton 19a. Informant's Name/Relationship (Type, Print) personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lingwai (Sister) 3823 Aldino Road, Aberdeen, Maryland 21001 other t rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 9/1/04 West Chester, PA 21. Signature of Funeral Service Licensee ²Tarring-Cargo Funeral Home, P.A. Tara C. Zellman per dvr Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GLUCOGONOMX 1995 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit Due to (or as a consequence of): physician Physician/Medical as use IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 힏 in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No director, page 2 should Completed 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attanding Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, within 24 hours a To tha Funara! the 0

Baltimore, Maryland 21215-0036

west 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIN EXHOMB 22 South 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature

29c. License number

State Registrar

(Check only one)

29b. Signature and title of certifier

# Horne. Lawin

68760,	
, P.O. Box	
n of Vital Records, P.O. Box 68760,	
Division of Vi	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day ()756 M CALVIN GRASON HORNEY, JR. August 93 9004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easten Talbot Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F 213-42-0102 61 Yrs. Director MARYLAND APR. 19, 1943 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ▼ No MD TALBOT **EASTON** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ONE KENSINGTON DRIVE 21601 USA Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 WATERMAN SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F Is marked of Pages 1 and 2 should be ment of Health and Menta ant: If item 27 is marked CALVIN GRASON HORNEY, SR. MILDRED ESTHER HOXTER ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I ELLEN HORNEY/WIFE ONE KENSINGTON DRIVE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. `4 ☐Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 08/27/2004 STEVENSVILLE, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My=(2/1/2/ Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 7.000 Sequentially list conditions, I any, todain g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) the death certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate I 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide 29a. Certifier i 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 8-23-54 algo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE ABREGO-GARCIA M.D., 598 CYNWOOD DRIVE, SUITE 104, EASTON, MD

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

AUG 2 6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** AUGUST 23, 2004 1:06 PM KAZUKO YAKUO HAMILL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GARRETT 224 E. ALDER STREET OAKLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year MAR 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕅 F Yrs JAPAN 213-44-6423 71 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at 11∑Yes 2 No Director GARRETT OAKLAND 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21550 USA 224 E. ALDER STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: f Yes, Give 23 Year or Dates: Specify: ASIAN Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YAKUO MATII unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 J 8388 KNOLLWOOD DR. ALLISON PARK, PA 15101 LINDA BECKMAN - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/24/04 MORGANTOWN, WV OMEGA CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 243 21. Signature of Funeral Servi M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HEPATIC FAILURE **Physician** 6 MONTHS resulting in death) /Medical Due to (or as a consequence of): Examiner HEPATITIS 6 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 Fetal death ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, peq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 💢 No Hospital or Attending Physician: filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier within 24 ho

To the Fune 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 24, 2004 D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. FOURTH ST. OAKLAND, MD 21550 THOMAS G. JOHNSON, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 4 2004 Registrar

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	Dharaist		1. Decedent's Name (First, Middle, Last,	)				2. Date of Death	1	Vana	3. Time o	of Death
	Physici /Medic		Constance	Sue	Humberso	n		August	23, 20	Year 04	4:00	Р м
	Examin	er	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De	eath	4c. County of	f Death		
			25422 Garrett Hig		- de la bida		McHenry	leo lo a company		Garre		
	Funeral Director		5. Social Security Number 6. Sec	x /.Ag JM 2⊠F	je (In yrs. last birthda F7 Yrs.	y) If Under 1 Year Months Days		in. (Month, Day,	Year)		ace (State try)	or Foreign
			220-58-0412 Usual Residence of Decedent		57_ Yrs.			Jan.30,	1947	Mary	/land	
	ylanc how		10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside C	City Limits
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	ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	ry?	
	s 23s		25422 Garrett Hig				1541			USA		
	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2∑1		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- America , White, e		
39	irs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO	1 ☐ Yes 21 No	Specify:		Specify:	V	Vhite	
ဝို	2 hor	ted	15. Decedent's Edu	cation	16a. De	cedent's Usual Occur	pation	,.   1	6b. Kind of Bus	iness/Ind	ustry	
7	thin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or t	life	ve kind of work done  DO NOT use retire	d) auring most of t	vorking				
7	ed wi	Completed	12th			Homema				Home		
ᇤ	be fil ntal H ad oth svan	Be	17. Father's Name (First, Middle, Last) Ver1	Pol	cer, Sr.		18. Mother's N	lame (First, Middle, M		,	. 4	
Maryland 21215-0036	hould d Mer marke matic	ဦ	19a. Informant's Name/Relationship (Ty			iling Address (Street		Rural Route Number,		tewar		
<u>≅</u>	treul		Richard A. Humbers					vay, McHeni	•			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menalla Hygiene. Important: If tier and I have Hygiene. I minorant: If tier and I is marked other then "neturel", or items 23s or 28e-f show any injury or other treumatic svent, I'm Medical Eraci incr must be todified at once.	į	20a. Method of Disposition	-	20b. Place of Dis	position (Name of rematory or other place			Oc. Location - C		_	
Ę	Page lent o nt: If ry or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ P  '4 ☐ Donation 5 ☐ Other (Specify)			Co. Mem.	1	/26/04	Dakland	Маз	cul and	a
ä	rmit. partm porte y inju		21. Signature of Funeral Service Licens	990	Journey	22. Name and Addre		Stewart Fu		-	.y Laire	4
<u> </u>	89 = 9		Scally 1.	Litton		32 S. Seco	ond St.	Oakland,	Md. 215	550		
	Hysician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final	ne cause on each li	ne.		ng, such as card	iac or respiratory arres	st,		Approximat Interval Bet Onset and	tween Death
	/Medical		disease or condition resulting in death)	Due to (or as	c Amyloid a consequence of):					- 5	year	
	Examiner		Sequentially list conditions,	b	le Myelom	3				2	year	S
	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
	xecut and at-tran	хап	that initiated events resulting in death) Last	Due to (or as	a consequence of):							
8760,	icate be executed physician and s the burial-transit	dical			. ,							
89	ifficate g phy as the	edic		J								
ŏ	eath certific attending p	by Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome		B⊟Ectopic pregnancy	,		23d. Date	of deliven	y	
P.O. Box	b dea he att	sicia	in the past 12 months2	4□Pregnant at		Other (specify)			Monti	ı D	Day ^	Year
<u>.</u>	res that the de signed by the a be detached t	Phy	9 Unknown		ut ant moulting in the		an in Dani I	22a Did taha				4
Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions cor	minouting to death b	ut not resulting in the	underlying cause giv	en in Parti.		cco use contrib	ute to the □ Probat		enknown
မင် မင်	law r las be	Completed						24a. Was an autopsy	24b. We	ere autops	sy findings pletion of c	available
		Con						performe	No 1	ath? Yes 2	.□ No	
<b>S S</b>	Physicien: The this certificate rate director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth		eath (Check only one)				
	두 두 편	<u>د</u>	1 Yes 2 No	1 ☐ Inpatie			4 🗀 Nursing	Home 5 Residen 28d. Describe how				
5	Attending I r death. ector: After by the funer	tlon	1 → Tatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Year) Injury	Wor	k?¨ Yes 2 ∐ No	200. Bosaribo riovi	injury occurred			
Division of	Atter er dea rector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home, farm,	street, factory, office		28f. Location (Stre	et and Number	or Rural I	Route Num	ber,
ā	spitel or ours afte nerel Dir filled in I	Certification:	4 - Nomicide	building, etc	с. (Эрөспу)			City or Town,	State)			
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examination	sician: To the best oner: On the basis of and manner sta	examination and/or	ath occurred at the tin investigation, in my o	ne, date and pla pinion, death oc	ce, and due to the cau curred at the time, date	se(s) and mann e and place, and	er as stat d due to ti	ed. he cause(s	()
1	vithi To t	Ž	29b. Signature and title of certifier			29c. Licens	e number		1. Date signed (		y, Year)	
			10		-	I	15333		08/24/2	004		
			30. Name and address of person who co	·			1.1	M1 01550				
	Sta	e	Thomas G. Johnson 31. Date filed (Month, Day, Year)		I N. Four ar's Signature	th St., 0a	KLand,	ma. 21550				
	Registra			004	www. A	STONE F						

			For State Registrar		State o		nd / Dep		t of H	leaith a	and Menta	al Hygi			291.	1. 2
G.	Physic	ian	1. Decedent's Name	(First, Middle, Lewis								te of Death	Day	Year	3. Time of	Death
	/Medi	cal			Hughes						Augu	ist ]		2004	2:35	АМ
	Examir	ner	4a. Facility Name (If Southern				- 0.76			Location of	f Death			ounty of Death		
	Funeral		5. Social Security No		6. Sex	7. Age (In yrs.			1 Year	If Under 2		e of Birth		ince Ge	orge's	or Foreign
	Director		228-48-05	10	1 <b>∑</b> M 2□F	64	Yrs.	Months	Days	Hours	Min. (Mo	onth, Day, \		9 Milto	place (State on try)	n i Greign
	and w		Usual Residence of 10a, State	Decedent 10b. County		10c Ci	ity, Town or L	ocation								
	Maryla f sho	ō			George's		iitland								0d. Inside Ci	ity Limits 2 ☐ No
	the the	rect	10e. Street and Nurr					10f. Zip	Code			100	Citiza	n of What Cour		
	3a or	0	6715 McK	eldin T	rive					746					•	
	deat	nera	11. Marital Status		12. Was Dece	Ident Ever in U	J.S. 13.	Was Deced			in? (Specify Ye Puerto Rican,			ed Stat Race Americ	an Indian.	
36	or Ita	y Fu	1 Never Marrie		d 1XXYes If Yes, Giv	rces? 2 No 196	2-	1 ☐ Yes 2		n, mexican, Specify:	Puerro Hican,	91C.)		Black, White,		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show is Madical Examiter and the motified at	Completed by Funeral Director	3 Widowed		1001010	ates: 190	J						5,	pecify: Bla	ck	
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212	d with jiene.	mo	Elementary/Secon	ndary (0-12)	College (1	-4or 5+)	Mecha		io roinog,	,			Met	ro		
	be filed tal Hygie d other event, II	a	17. Father's Name (	First, Middle, L	ast)					18. Mother	's Name (First,					
<u>Jar</u>	should be ind Mental imarked o	To B	John C.	Hughes						East	er B. B	rando	n			
Maryland	2 sh and is m		19a. Informant's Na								or Rural Route	Number, C	City or T	own, State, Zip	Code)	
	1 and Health am 27			Hughes	/ Wife	001	6715			Dr.	Suitla	_				
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr once.			Cremation 3	B □Removal from	State	Place of Dispo cemetery, crei	matory or of	ther place	9)	Date	20	c. Loca	tion - City or To	wn, State	
計	permit. Pages Department of Important: If it any injury or c		* 4 □ Donation  21. Signature of Fun			Ft	. Linc				/24/200	4 Br	entv	ood, M	)	
Ba	permi Depa Impo any i		21. Signature of Fur	O. T.	Lensee Lenset		F	2. Name and	d Addres	s of Facility n _Fune	eral Ho	me .				
			23a. Part1. Enter th	e disease, or o	omplications that cally one cause on ea	aused the deat	th. Do not ent	er the mode	of dying	nsburg	ardiac or respir	rentwo	ood,	MD 20	722 Approximate	Α
	Physician /Medical Examiner	Examiner	Immediate Cause (Fidisease or condition resulting in death)  Sequentially list confiant, leading to immediate. Enter Under Cause (Disease or in that initiated events	1	b	or as a consequence as a consequence	juence of):	FT	HE	L	UNG				Interval Bety Onset and D	)eath
O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Exar	IF FEMALE: 23b. Was decedent in the past 12 n 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	pregnant nonths?	d	nth 2 ∐ Feta antat time of d	ancy	Ectopic pre					23d	. Date of delive		'ear
۵.	res that the igned by be detact	by Ph	Part II. Other signific				-				236	. Did tobac	co use	contribute to th	e cause of de	ath?
ord	w require been sig should b		PERICAR	WAL	EFFUS	7			VG		_	1 ✓ Yes	2 🗆 N	lo 3 ☐ Proba	ably 4 □U	nknown
Vital Records,	The ate h page	Completed	1HHROM FAILU	13051		EMIA MBO C				TOR		. Was an autopsy performed Yes 2 🔽	1?	4b. Were autop prior to con death? 1 \( \sum \text{Yes}	pletion of ca	vailable use of
Vit.	Physician: this certific ral director,	Be	25. Was case referre examiner?		Hospital:						f Death (Check					
of	Phys r this ral dii	To.	1 ☐ Yes 2 ☑ ↑	10	1 601	patient 2 🗆	ER/Outpatien 28b. Time of		c. Injury	4 ☐ Nursi	ing Home 5	Residence	9 6 □	Other (Specify,	)	
on	th. : After s funer	ton	1 Natural 2 Accident	5 Pending investigation		t Injury 7, Day Year)	Injury	M	Work?	at ? es 2 □ No		cribe how i	njury od	curred		
Division	or Attending after death. Diractor: After in by the fune	ertification:	3 🗌 Suicide	6 Could no	t be 28e. Place	of Injury - At he	ome, farm, stre			00 2		ition /Stree	t and N	umber or Rural	Route Numb	oar
ă		Cert	4  Homicide		buildin	g, etc. (Specify	y)	,			City	or Town, S	tate)			51,
	To tha Hospital or within 24 hours after to tha Funeral Discompletely filled in	edical (	29a. Certifier (Check only 2 one)	ft Certifying 2 ☐ Medical Ex	Physician: To the aminer: On the ba and mann	sis or examina	wledge, death tion and/or inv	occurred a restigation, i	t the time in my opi	e, date and p nion, death	place, and due occurred at the	to the caus time, date	e(s) and and pla	i manner as sta ce, and due to	ited. the cause(s)	
	To tha within 2 To tha complet	M	29b. Signature and ti			-			License			29d.	Date si	gned (Month, D	lay, Year)	
)			1	~ A	ATTEN D	ING	PHYSI	UAN	DS	290	C	0	8 -	20-	2004	_
C	R (3)		30. Name and address	ss of person wh		of dooth (Itam	220) (Time I	Deinal			V # 301	LAN	Dov	GR MI	207	85
	Sta Registr		31. Date filed (Month		<b>3€</b> . Re	gistrar's Signa	ture						<u> </u>		- 1	

			1 - For State Registrar	State of M	larylan	•	artment rtificate					iene	004	28444
£.	Physici	an	1. Decedent's Name (First, Middle, Helena C. H	,							2. Date of Dear	Day	2004	3. Time of Death 8:00 PM
ř	/Medie Examir	al	4a. Facility Name (If not institution,		)		4b. City, To	own, or	Location of	of Death	August	1	ounty of Deeth	1
	Exami	er	Washington			tal	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		koma				Montgo	
	Funeral				ge (In yrs.	last birthday)	II Under 1 Months		Il Under Hours		8 Date of Birth	Year)	9. Birth	plece (State or Foreign intry)
	Director		246-46-2882 Usuel Residence of Decedent	10 M 2001	89	Yrs.					Dec. 4,	191	4 Ter	nessee
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	B Mar	ctor	Maryland Princ	e George's			7	emp	1e H:	ills				1 →Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip C		0071	_	1	_	n of What Cou	-
	eath v	eral	3602 - 24t	h Ave.	t Ever in III	S 12	Was Docodo		2074		oifu Voe or No		United . Race - Amen	
220	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other then "natural", or Items 23e or 28e-f show reumatic event. The Medical Examinat must be motified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	?  No		Yes, specif				ecify Yes or No- Rican, etc.)		Black, White	
5	72 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual kind of work	Occupa	tion	et of worki	na	16b. Kind	of Business/Ir	
Z	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)			ng			
7	Hygier Hygier Ther th	Co	12th 17. Father's Name (First, Middle, La	et)			F	lome	make:		(First, Middle, I	Maiden S	Priv	rate
Baltimore, Maryland 21215-0036	d ta b	To Be	Watt Brya	nt						Fa	annie Mc	Вее		
Mar	d 2 sh h and 7 is rr traum		19a. Informant's Name/Relationship Daniel N. Howa		Son		ng Address (				I Route Number	City or 7 2002		o Code)
a P	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 2006.	3	20a. Method of Disposition		20b. P	Place of Dispo	sition (Name	of	1			20c. Loca	ition - City or T	own, State
Ē	Pages nent of ant: If It ary or o		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			emetery, crei Linco				8/25,	/2004	Br	entwood	i, MD
3 2	Departm Departm Importar any inju		21. Signal re of Funeral Service Lie								tewart F	uner	al Home	<u> </u>
<u>מ</u>	8838	9.0	John T.	newar 1	I						, N.E.		., DC 2	20019
	Pnysician /Medical	r i	23a. Part I. Enter the disease, or co shock of heart failure. List or Immediate Guuse (Final disease or condition resulting in death)	Aspi	ratio	n Pneu		of dying	g, such as	cardiac o	r respiratory arre	əst,		Approximate Interval Between Onset and Death
	Examiner			Due to (or a: Cere		uence of): Stroke								
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as										
	cate be executed oblysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c		erosis.	<b>.</b>							
Ď,	oe execian a		resulting in death) Last	Due to (or as	s a conseq	uence of);								
98/60	physical physics the t	dical	`	d									-	
POX P	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome								236	d. Date of deliv	erv
o B	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic preg Other (spec		· · · · · · ·		<u>.</u>		Month	Day Year
7	res that ti igned by be detac		Part II. Other significant condition	contributing to death	but not res	ulting in the u	nderlying cau	se give	n in Part I.		23e. Did tob	acco usa	contribute to t	he cause of death?
	quires in sigr uld be	ed by	Gastral	Intestinal	Blee	eding					1 □ Ye	s 2 🗀	No 3 ☐ Prol	bably 4 Hunknown
O O	e law requir has been si je 2 should l	Completed									24a. Was a		24b. Were auto	opsy findings available
ř		Com									autops perform		death?	mpletion of cause of 2 No
Vital Records,	nysician: Thinis certificate	Be	25. Was case referred to medical examiner?	<u> </u>							(Check only on	9)	re-	
ō	Physi this c	. To	1 ☐ Yes 2 💢 No 27. Manner of Death	Hospital:		ER/Outpatier 28b. Time of		Othe	r: 4 □ Nu		ne 5 Reside			(y)
	ding In. After	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)	ay Year)	Injury	M	. Injury Work 1 □ Y	ai ? ′es 2.⊟i		28d. Describe ho	w injury c	occurred	
DIVISION	I or Attendi after death. Director: A	Certification;	3 Suicide 6 Could no	t be 28e. Place of Ir	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, lactory,			-	28f. Location (St. City or Town		Number or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 1 Certifying (Check only 2 Medical Ex	Physician: To the bestaminer: On the basis	t of my kno	wledge, death	occurred at	the time	e, date an	d place, a	and due to the ca	iuse(s) ar	nd manner as s	stated.
	the hin 24 the F	Aedical	Unbj	and manner s	tated.	con and/or in				u i occurre				
	Will To	Σ	29b. Signature and title of certifier				29c. !		number	1	29		signed (Month,	
		10	30. Name and address of person wh	no completed course -1	doath /lin-	23a\ /Tu==	Print'	ע	1997	T		Au	gust 19	9, 2004
	G2-12	/		7 N	( D	7610 (	orrol'	l Av	ле.,	#230	, Takoma	a Par	k, MD	20912
	Sta		31. Date filed (Month, Day, Year)  ALIG 2. 5. 20	Regist	rar's Signa	ture								

Charlie Hicks 04LC

Formal Direction  Figure 1  Formal Direction  Figure 2  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Direction  Formal Dir	05428		ricase	State of Manyland / Den		•	•
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Prince Cacongo 'e Montal a Centror  230-869-8746 a 500 x 2			Charlie L. Hic	:ks			1 1
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Female:   23b. Was decedent pregnant in the past 12 months?   1   1   25c.   1   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   1   25c.   25c.   1   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c.   25c	/Medical Examiner	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, iscome to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	of Chest		
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Name and address of person who completed cause or death (Item 23a) (Type, Print)  Tasha Z Grunbura Month, Day, Year)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause or death (Item 23a) (Type, Print)  Tasha Z Grunbura M.D.  31. Date filled (Month, Oay, Year)  29c. Registrar's Signature		tifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, st		28f. Location (Street	and Number or Rural Route Number,
Part of the state of person who completed cause or death (Item 23a) (Type, Print)  Tasha Z Greenberg M.D.  31. Date filed (Month, Oay, Year)  P. Registrar's Signature  O.C.M.E. August 23, 2004  111 Penn Street, Baltimore, Maryland 21	tal or rs afte al Dir	O	7		vilding hallway		
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			31. Date filed (Month, Oay, Year)  AUG 2 6 2004	P. Registrar's Signature	A.	-	. 1

			For	State of Mary	land / Depa	artment of H	Health and M	•	3	ole.
_			1 - State Registrar		Ce	rtificate of	Death	Re	g. No. U	14 28446
	Physici /Medi		Decedent's Name (First, Middle, Last     Jesse James Holme:	S				2. Date of Death Month <b>August</b>	Day 20	3. Time of Death  904 6:41 a
Sandar.	Examir	ner	4a. Fecility Name (If not institution, give	·		4b. City, Town, o	or Location of Death		4c. County of	of Death
	·		Prince George's Ho		a considerate de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria del factoria de la factoria de la factoria del factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria del la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la factoria de la fact	Chever1			Prince	George
, p	Funeral Director		2	XM 2∏F	n yrs. last birthday) Yrs.	Months Days	Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>		Birthplace (State or Foreign Country)
<b>A</b> -			Usual Residence of Decedent	70	U			Sep. 3,	1933	Florida
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itama 23a or 28a-1 show event, i're Medical Exam are must be myllied at	tor	10a. State 10b. County  Maryland Prince G		c. City, Town or Lo					10d. Inside City Limits 1    Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?
	th wi	a	4208 Leisure Driv	'e		20748		τ	Jnited S	States
	r dea	Iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto		14. Race	- American Indian, c, White, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🐴 No If Yes, Give	1	1 ☐ Yes 2 ☒ No	Specify:	, mount, otoly	Specify:	D1 1
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12	withir ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)			0)			
d 2	ould be filed v Menta! Hygie harked other t		17. Father's Name (First, Middle, Last)		Labo	rer	18. Mother's Name	(First Middle M	Privat	
an	d be antal	o Be	Unknown				Unknown	(	aroon ournaine	"
Maryland	s 1 and 2 should be filed f Health and Menta! Hygi item 27 is marked other other traumatic event, I	은	19a, Informant's Name/Relationship (T)	vpe. Print)	19h Mailir	n Address (Street	and Number or Rura	J Route Number	City or Town 5	State Zin Code)
Ma	nd 2 s lith ar 27 is 27 is			20,11111			Lane, Bow		20716	state, Zip Code)
ē	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra ance.		Elijah Holmes/Son 20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of	i - c	West State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the		Dity or Town, State
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Ba	Depa Impo any is		011/2/2	nelli	I	lexander	S. Pope	Funeral :	Homes	
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	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	chronic I	Renal Fai			,		Interval Between Onset and Death
۲.	Examiner			Due to (or as a co						
	* 38.	ē	Sequentially list conditions,	b. Due to (or as a co						
	te be executed ysician and ne burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	Hypertens						
,	exect n and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as a co						_
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89	ficate pphy is the	edic		1.						
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P.0	that the de led by the detached	hy	9 Unknown							
Ś	w requires th been signed should be de	by	Part II. Other significant conditions con	atributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	11		oute to the cause of death?  B Probably 4 Unknown
Vital Record	aw re Is be	ompieted						24a. Was an	24b. W	ere autopsy findings available
Œ	The lavate has	E						autopsy	ed? de	ior to completion of cause of sath?
ital	ician: Th certificate ector, pag	e C	25. Was case referred to medical				26. Place of Death	(Check only one		Yes 2 X No
<b>/</b>	dis d	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1   Inpatient	2 ER/Outpatien	t 3 DOA Oth				(Specify)
			27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Worl	vat 2	8d. Describe how		
<u>Ö</u>	Attending I r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 198	ar) Injury		Yes 2 □ No			
Division	al or Attena after deat Director: d in by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)		eet, factory, office	2	8f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physical Chack only 2 Medical Examinates	sician: To the best of my ner: On the basis of exal and manner stated.	/ knowledge, death mination and/or inv	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	se(s) and mann e and place, an	ner as stated. Indidue to the cause(s)
	To the F within 24 To the F complete	Me	29b. Signature and title of certifier		17	29c. License	a number	290	I. Date signed (	(Month, Day, Year)
	. , , ,		1/2 1.0	Un PALLO	1	10	035723	2	5 A	11-11
^	00		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	Print)	70/-		1/5	ag
C	K (3)		Judith Abboud, M.I		go Road,		20772			)
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature					
	Registr	ar	AUG 2 6 2004	likere	K los	de				

54	1.8		Please	Type or Print in					_	
			1 - For State Registrar	State of Maryla		artment of F			iene 99. 1988.	28447
	Physic /Medi		1. Decedent's Name (First, Middle, Last Jeannette	Denice	Ja	ckson		2. Date of Deat Month August	Day 2004	3. Time of Death
	Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Examinum Exa	ner	4a. Facility Name (If not institution, give South bound I-270 5. Social Security Number 6. Se 212-78-9770		rs. last birthday) Yrs.	4b. City, Town, of German If Under 1 Year Months Days	or Location of Death  COWN  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day,	Yearl Go	ery hplace (State or Foreig
	D	rector	Usual Residence of Decedent  10a. State  10b. County  Montgo  10e. Street and Number	10c. (	City, Town or Lo	. /	llage	April 7,	0g. Citizen of What Co	10d. Inside City Limits 12 Yes 2 \( \text{No.} \)
036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Modical Eventine must be redified at	by Funeral Director	20308 Grazina  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes, Give Year or Dates:		208	3 8 6  Hispanic Origin? (Spean, Mexican, Puerto  Specify:		USA  14. Race - Ame Black, White Specify: 8/0	rican Indian, e, etc.
d 21215-0036	filed within Hygiene. ther than " nt, the Me	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Give life. Sec	dent's Usual Occup kind of work done DO NOT use retired Cretari	during most of worki d)	ng J	16b. Kind of Business/ HOUSING 1angeme	,
e, Maryland	is 1 and 2 should be in Health and Mental I item 27 is marked oother traumatic eve	ToB	19a. Informant's Name/Relationship (TySHIKA SY	nith	19b. Mailir 980	8 Feat	Glovic and Number or Rura hertree	Poll Route Number, Terr, M	City or Town, State, 2	Village Md.
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lickel	lemoval from State	sthave	n Mcm.	ca) /	× 12004 7	Frederichen Md. 217	k Md.
AL PARTY	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
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Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditions cor	tributing to death but not re	esulting in the ur	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	
Vital Records,	The ate his page	e Completed	25. Was case referred to medical					1	ed? prior to condeath?	opsy findings available ompletion of cause of 2 No
n of	ding Phys h. After this funeral di	Certification: To B	examiner?	28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At building, etc. (Spec	28b. Time of Injury 2:20 home, farm, stre	28c. Injury Work 1 D	y at 2 Yes 2 No 2	ne 5 Resider 8d. Describe hov  2 b lt+  8f. Location (Stre City or Town,	nce 6 🖾 Other (Spec	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physical Check only one)	ilcien: To the best of my kr ter: On the basis of examin and manner stated.	nowledge, death	occurred at the tim	ne date and place a	nd due to the car	iso(s) and manner as	etated
ŧ	To t To t	Σ	29b. Signature and title of certifier  Zau ut		7 r	29c. License			d. Date signed (Month, August 22,	,
_	6		30. Name and address of person who co	mpleted cause of death (Ite			Street, B	altimore	e, Maryland	1 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature	,	4			

Registrar

AUG 2 5 2004

			1 - For State Registrar	State of Mary	•	rtment of H			ene	201.1.0
	Physici		1. Decedent's Name (First, Middle, Last) William	F.	Jones			2. Date of Death Month August	Day Year	3. Time of Death 8:35 A M
	/Medic Examir		4a. Facility Name (If not institution, give si Calvert County		Center	4b. City, Town, or Prince	Frede1	th	4c. County of Deal	th
	Funeral Director		5. Social Security Number 6. Sex 216-28-3484 12	M 2□F	yrs. last birthday) 82 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birt 922 Mai	hplace (State or Foreign buntry) Cyland
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  Maryland  Calve		c. City, Town or Lo	cation nesapeak	ce Beac	h		10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23s or 28 191 be no	al Director	10e. Street and Number 4051 Christia	nna Parra	an Road	10f. Zip Code	732	100	g. Citizen of What Co USA	ountry?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show aumatic evant, Itie Maddeal Expringer must be inclified at	by Funeral	11. Marital Status 1 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: B1 a	e, etc.
21215-0036	within 72 horene. ene. than "natura its Medical B	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occupa kind of work done d DO NOT use retired,	ation furing most of wo	rking	Construc	
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	5 ₹ 7 ±		19a. Informant's Name/Relationship (Type Charles Jones/s	on	8807	Danger		ural Route Number, C Rd. Cli	City or Town, State, 2 nton, MI	
altimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		Ward's U	JMC Cem.	8/2	7/04 0	c.Location-City or Wings, M	1D
Balt	permit. Page Department Important: II any injury o		21. Signature of Funeral Service Licenses  **Dlady** A. S	levell	Pi	51 Dare	s Beac ederic		678	ıe
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the e cause of each line  Due to (or as a co	ric	Can C e	g, such as cardiad	c or respiratory arrest	,	Approximate Interval Between Onset and Death
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ion of Vital	ž sic	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manger of Death  1 Natural 5 Pending investigation	espital: 1  Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 Nursing H	ath (Check only one)  lome 5 TResidence  28d. Describe how		ify)
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	the Hosp hin 24 hou the Funer npletely fil	Medical	one) 2   Madical Examine	cian: To the best of my export the basis of exa and manner stated.	y knowledge, death mination and/or inv	estigation, in my opi	inion, death occu	rred at the time, date	and place, and due	to the cause(s)
	Twil Fo		29b. Signature and title of dertifier	7		29c. License	1999	29d.	Date signed (Month	( Jay, rear)
	5		30. Name and address of person who comes 31. Date filed (Month, Day, Year)	V) Gallo	(Item 23a) (Type, F	Print) HOSP	il Ro	Sure	-310 Po	me Rederal
	Sta Registr		AUG 2 3	2004	are B	South		1		MAN COPED

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Physici /Medic		ROLAND	M.	JOHR				2	Month	Day	2004	C3. Time of Death
Examir		4a. Facility Name (If not institution Howard County	General Ho	spital		4b. City, Town, o			Date of Birth		County of Death	
Funeral Director		5. Social Security Number 217 26 1765  Usual Residence of Decedent	6. Sex. 1 M 2 □ F	7. Age (In yrs. I	Yrs.	Months Days	Hours	Min.	Month, Day,	Year) 192	Col	place (State or Foreig intry) ryland
e Maryland 3e-f show	ctor	10a. State 10b. Count	_y ward		, Town or Lo lli∞t	t City						10d. Inside City Limit
30 or 21	al Dire	10e. Street and Number 8720 Ridge Roa	d Apt 407			10f. Zip Code 2104	3		1		ien of What Col	•
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 ie marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 252 Ma 3 Widowed 4 Divorce	12. Was Dece Armed For 172 Yes			Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Orig an, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		4. Race · Amer Black, White Specify: B	
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2 should be filed and Mental Hygi ie marked other reumatic event,	To Be Co	17. Father's Name (First, Middle Elwood Johnson			- DIIV				First, Middle, I			
nd 2 sho lth and 27 ie mu treuma		19a. Informant's Name/Relation Helen I. Johns			1	ig Address (Street Ridge Ro				-		
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permit. Pages Department of Importent: If i eny injury or otice.		21. Signature of Funeral Service		01044	22	. Name and Addre	ss of Facility	Harry	H. Wi	tzke	e's Fami	lly FH Inc , MD 21043
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	st only one cause on each $\frac{2}{2}$	ach line.	nema	er the mode of dyir						Approximate Interval Between Onset and Death
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w requires that the been signed by the should be detache	by	Part II. Other significant condit	tions contributing to de	_	-	, , ,	en in Part I.		23e. Did tot			the cause of death? bably 4 □Unknow
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Attending Physicien: 'r death. r death. ector: Atter this certifica by the funeral director, p	To Be	25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend inves	Hospital: 1 28a. Date of	npatient 2 🗆 of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Injur Wor	er: 4 🗆 Nur	sing Home	Check only on 5 ☐ Reside d. Describe ha	ence 6	Other (Spec	ity)
or in line	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 28e. Place buildir	ng, etc. (Specif)	/)	eet, factory, office			City or Town	, State)		ral Route Number,
는 무무 마이	edical	29a. Certifier 1 Certify (Check only one) 2 Medics	ring Physician: To the al Examiner: On the ba and mann	asis of examinat	wledge, death tion and/or in	vestigation, in my c	ne, date and pinion, death	n piace, and h occurred	a due to the call at the time, d	ause(s) a ate and	place, and due	stated. to the cause(s)
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102		30. Name and address of perso	n who completed caus	e of death (Item		Print)						o) on bic

		_	, rot	artment of Health and Menter artificate of Death	tal Hygiene
			Decedent's Name (First, Middle, Last)	2. D	ate of Death 3. Time of Death
	Physicia /Medic		Velva Marie Johnson		Month Day Year 11:01 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Doctors Community Hospital	Lanham	Prince George's
	Funeral Director		5. Social Security Number  217–34–1926  6. Sex  1 M 2 K F 66 Yrs.	Months Days Hours Min. (A	hate of Birth Month, Day, Year) 0/15/37  9. Birthplace (State or Foreign Country) College Pk., Md.
	anyland show	7.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Md. P.G.	ocation College Park	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-1	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w		4711 Berwyn House Road # 418	20740	U.S.A.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exerting must be notified at	by Funerai	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify' If Yes, specify Cuban, Mexican, Puerto Ricar  1 ☐ Yes ※☐ No Specify:	Yes or No- h, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	within 72 ho ene. than "natur he wedicul	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
	filed withi Hygiene. other than ent, the M	Con		sekeeper	Federal Government
Maryland	should be fill and Mental H s marked ott umatic even	To Be	17. Father's Name (First, Middle, Last)  George Smith, Sr.	,	ae Potts
ary	2 should have and he ls ma			ing Address (Street and Number or Rural Rou	· ·
-	1 and 2 Health tem 27				3, Beltsville, Md. 20705  20c. Location - City or Town, State
Ore	Pages 1 ar		1 XBurial 2 Cremation 3 Removal from State	ematory or other place)	
Baltimore	permit. Page Department o Important: If any injury or once.			ChapelMeth.Ch.Cem.8/	
Ba	permit. I Departm Importal any inju		Sang W. Shau	H.S. Washington & Son 4925 Burroughs Ave.,	N.E., Wash., D.C. 20019
	Physician	8 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ke. W.A. 225/18	piratory arrest, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	-0 0.00 201	
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a root wife	etery.
	nd nd transit	Examiner	that initiated events	nal caroticly	occlusion
60,	be executed sicien and burial-transit		resulting in death) Last  Due to (or as a consequence of):	'M	
09289	physics the l	dicai	d. rujunesse	270.	
.O. Box (	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
4	juires that the de n signed by the a lid be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
of Vital Records,	he law requir e has been si age 2 should	Completed by	Hyperlipidomia		24a. Was an autopsy findings available prior to completion of cause of death?    Yes 2   No
ital		0	25. Was case referred to medical	26. Place of Death (Chi	
	Physiclan: this certific ral director,	To B	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie		5 ☐ Residence 6 ☐ Other (Specify)
	Attending Pl death. ctor: After ti y the funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)	of 28c. Injury at Work?  M 1 Yes 2 No	Describe how injury occurred
Division	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ocation (Street and Number or Rural Route Number, City or Town, State)
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.		
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			1	D14905	8/21/04.
(	f (5)		30. Name and address of person who completed cause of death (Item 23a) (Type XAR-KOON H. YOON). 7307 BA	ALTIMORE AUG. =	ma. 20140 # 111. College Park
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 2 5 2004  22. Registrar's Signature	de	

		1	For State Registrar		Maryland / De		f Health and I of Death	Mental Hyg	•	28451
-			. Decedent's Name (First, Middle, Last	')		14		2. Date of Deat	th	3. Time of Death
	/siciar ledica		Maeola Jones-B	utler_				08	21 O4	2:00 A M
1	amine		a. Facility Name (If not institution, give	street and numbe	r)	4b. City, Tow	n, or Location of Death	1	4c. County of De	ath
	4		Washington Adven . Social Security Number 6. Se	tist Hos	piţal	Takoma			Montgome	
Fune Direc		1		x ]M 2127F   7.7	tge (In yrs. last birthd 90 Yrs	Months Da		8. Date of Birth (Month, Day,	Year) 9. B	inhplace (State or Foreign Country)
	.101	-	Join Tesidence of Decedent		90			04 06	14 50	rother S.C.
nylan	<b>3</b> .	- 1	Oa. State 10b. County		10c. City, Town o					10d. Inside City Limits
e Ma	1	2	D.C.		Washir	ngton				XXYes 2 □ No
ith th	by Funeral Director	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	0e. Street and Number			10f. Zip Cod	le	1	0g. Citizen of What (	Country?
ath v	io.		5001 4th. Street N			2001			USA	
ler de	a di	י בו	1. Marital Status	12. Was Deceder Armed Forces	?	<ol> <li>Was Decedent of Yes, specify C</li> </ol>	of Hispanic Origin? (Sp Suban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, vite, etc.
336 urs af	2	7	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 Tyes 2 1 If Yes, Give Year or Dates		1 ☐ Yes 2 🖺	No Specify:		Specify: B1	ack
21215-0036 d within 72 hours after death with the Maryland glene. er then "neturel", or Items 23e or 28e-f show	Completed	2 -	15. Decedent's Edu	ication	16a. De	ecedent's Usual Oc	cupation		16b. Kind of Busines	s/Industry
215 Pin 7	aid.	<u> </u>	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4o	(G (if	ive kind of work do e. DO NOT use re	ne during most of worl tired)	king		
Maryland 2121: 2 should be filed within hand Mental Hygiene. 7 is marked other then "		5 _	9th.			xaminer			Dress S	hop
Maryland d 2 should be file th and Mental Hy 17 is marked oth	By B	ם 1	7. Father's Name (First, Middle, Last)  Dhilip H Mohlow					ne (First, Middle, A		
Yla Yla Men Men Men Men Men Men Men Men Men Men	L C	2 _	Philip H. Mobley					a Lightne		
Mar 12 sh h and 7 is m		ï	19a. Informant's Name/Relationship (T)				eet and Number or Ru			
C = 19 1		-	Jerome Manigan/No Oa. Method of Disposition	epnew	20h Place of Di	3 S. Dako	ota Ave. N.			
	ă l	-	1 Burial 2 Cremation 3 □F		•	sposition (Name of crematory or other	i		20c. Location - City o	
Baltimo permit. Page Department of			<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>		Fort LI		8-27. dress of Facility Ma		Brentwood,	
Depris	ODC .		O to a l	0.0	Į		. St. N.W.			
	7	+	23a. Party. Enter the disease, or compleshock, or heart failure. List only o	ications that cause				_		Approximate
Description			mmediate Cause (Final	ne cause on each	line.					Interval Between Onset and Death
Prysici /Medio			disease or condition esulting in death)	a	sa consequence of);	ro ar	The Sho	ck		
Examir	nėr			1	0101×8	En I	ullin.			
A LOUIS	je i	5	Sequentially list conditions,	Due to (or a	sequence of):	1		-		
cuted	Examiner		Sequentially list conditions, 1 y, team of Inderlying Lause (Disease or injury hat initiated events occulting in death). Let	s	Knoun	ronia	_			
Box 68760, death certificate be executed e attending physician and of or use as the burial-transit	EX	រំ   '	esulting in death) Last	Due to (or a	s a consequence of)	1 :01	+			
68760, tificate be ex g physician as the burial	9 1.9	3		s. 4	nax p	brilla	tun			
Box 68 leath certificat attending phy for use as th	Physician/Med		F FEMALE:							
Box sath cert attending	an/	2	3b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ⊟Ectopic pregna	ncy		23d. Date of de Month	
at the de by the a	Vsic	2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant : 9□ Unknown	at time of death	5 ☐ Other (specify)	)		Widner	Day Year
<u> </u>	Ph	P	art II. Other significant gonditions cor	ntributing to death	but not resulting in the	a underlying cause	given in Part I	23e Did toh	acco use contribute t	to the cause of death?
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Cord  w require been significant should be	ete	-	1700		t = =====	0				
Records, The law requires tate has been signe	ι Ω	-	0/-	1 600	to coope	efact 1	equiz)	24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
	ပ်		5. Was case referred to medical	Cone	500 cos ac	iler as	ceroleut.	. 1 ☐ Yes 2	ID No 1 ☐ Ye	s 2□No
	0	1	examiner?	lospital:	ient 2 ☐ ER/Outpat	iont 30 DOA	<b>34</b>	th (Check only one		
	: ⊢	177	7. Manner of Death	28a. Date of Inj (Month, D		INTERIOR SELECTION	alury at Vork?	28d. Describe how	nce 6 Other (Spe	ecity)
Division of the standing Parter death. Director: After I din by the funera	Certification:		1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Monun, D	<i>ay Year)</i> Injur		Vork? ☐ Yes 2 ☐ No			
	tific		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir	njury - At home, farm, atc. (Specify)	street, factory, office	ре	28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,
Di itel or rs afte el Dir	Çe	5								
Hospitel 24 hours a Funerel I	edicai	2	9a. Certifier 1 Certifying Phys (Check only 2 Medicel Exami	sicien: To the bes	t of my knowledge, de	ath occurred at the	time, date and place, y opinion, death occur	and due to the car	use(s) and manner a	s stated.
the the	Medi		4/	and manner s	tated.					
5 with 50	3	:   2	9b. Signature and title of certifier	h-			ense number		d. Date signed (Mon.	
0 6	7			*5	MD	4	7867		8/23/0	9
K 19	5)	3	0. Name and address of personwho co		death (Item 23a) (Typ	e, Print)	Shington No	dupatro t	Hos Tak	one PKMd.
F 40 1	State	3	1. Date filed (Month, Day, Year)		rar's Signature		11001 740	400103	1103/1- 1001	wiel 11-11/0/
Reg	jistrar		AUG 25 2004	Bloom	N. Agos	We .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended item For #23a, Part 1, State of Maryland / Department of Health and Mental Hygiene Line A&B, & Part 11, per/physician, 9/1/04, WCHD, E.T. Amended 1 - Registrar item #20b, 20c, per funeral Rolling at 125 per 900, WCHD, D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes. Wolld | D.Hes 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 1204 Dampron Ime 08 /Medical 2004 4a. Pacility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisburg Wicomics Medical Center Regional If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Days Months Hours Min 10 M 2□ F 245-56-341 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be nutified at 1 ☐ Yes 2 ☐ No Director Jorce 01 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1864 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Excitation Yes 2 No 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ If Yes, Give 'Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced neturel Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then eny injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Elmbe: abor 18. Mother's Name (First, Middle, Maiden Surname) Be Ohn Illie eckstal ances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of James cemeter), crematory or other place Family, Stockton Rd Bernice ancs KNOW Md 21864 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Windsor N.C. 4 ☐ Donation 5 ☐ Other (Specify) emetar estorod Being Smith Tu Signature of Funeral Service Licens screl Ho P. O. BOX 331 Doco noko 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Carpionath Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2/2 No To the Hospital or Attending Physiclen: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٦ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 2 Accident investigation 1 Tes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 124 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I

AUL 31. Date filed (Month, Day, Year) State AUG 2 3 2004 Registrar

29b. Signature and title of certifier

305 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leur

29c. License number

ocomoke Cuh Ms

29d. Date signed (Month, Day, Year)

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The first instant of earth of the static property of the past 12 months?    The past 12 months?   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company			ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of cause.	of):	>00"	7=110-	77	0
Potential Companies of the past 12 months?   23d. If yes, outcome of pregnancy   1   1   1   2     5   1   1   1   2     5   1   1   1   2     5   1   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   1   2     5   1   2   1   2   1   2   1   2   2   1   2   2		ecuted and -transi	kami	that initiated events c.	4).				
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	760,	e be ex		d	·/·				
STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  STATE  ST	9	rtificat ng phy as th	Aedi	is service					
State  24. Was case referred to medical examiner:  25. Was case referred to medical examiner:  26. Place of Death (Check only one)  27. Manner of Death  28. Place of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of			ysician/A	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death		,			•
24a. Was an autopsy findings available of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	-	s that ined by	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
24a. Was an autopsy findings available of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	ords	equire sen sig ould b		COPD, ASCUD,	410	T	1 Yes	2 ☐ No 3 ☐ Proba	ıbiy 4 ⊡Unknown
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   31. Date filed (Month, Day, Year)   32. Registrar's Signature   31. Date filed (Month, Day, Year)   32. Registrar's Signature   32. Registrar's Signature   33. Date filed (Month, Day, Year)   32. Registrar's Signature   33. Date filed (Month, Day, Year)   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registr	I Reco	The law ate has b page 2 s	Comple	·			autopsy performed	prior to com death?	apletion of cause of
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   31. Date filed (Month, Day, Year)   32. Registrar's Signature   31. Date filed (Month, Day, Year)   32. Registrar's Signature   32. Registrar's Signature   33. Date filed (Month, Day, Year)   32. Registrar's Signature   33. Date filed (Month, Day, Year)   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registrar's Signature   34. Registr	Vita	icien: certific ector,	Be	examiner?	Oth.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	o	S S	h-	1 Inpatient 2 ER/Out	patient 3 DOA	4 Li Nursing Home		, ,	)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion	ath. r: Afte	atior	7	jury Work	k?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Divis	ai or Atte s after de: ii Directo id in by th	Sertific	determined 286. Place of injury - At nome, farr	m, street, factory, office	28			Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		he Hospit in 24 hour he Funere pletely fille		(Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time for investigation, in my of	ne, date and place, and pinion, death occurred	I due to the cause at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Vith To t		29b. Signature and title of certifier	29c. License	e number	29d. [	Date signed (Month, D	lay, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		wy wy	D	14262	1	09 26	2009
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			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar Certificate of Death Reg. NO. 1 1 28151	ı
	Physici		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  2. Date of Death	h D _M
	/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Berlin Nursing & Rehab. Ctr.  Berlin Worcester	
	Funeral Director		5. Social Security Number  5. Sex   7. Age (In yrs. last birthday)   10 Order 1 Year   11 Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Fore Country)    Usual Residence of Decedent   7. Age (In yrs. last birthday)   10 Order 1 Year   11 Under 1 Year   11 Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Fore Country)    Usual Residence of Decedent   7. Age (In yrs. last birthday)   11 Under 1 Year   11 Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Fore Country)    Usual Residence of Decedent   7. Age (In yrs. last birthday)   11 Under 1 Year   11 Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Fore Country)    Usual Residence of Decedent   7. Age (In yrs. last birthday)   12 Under 1 Year   11 Under 1 Year   11 Under 1 Year   11 Under 1 Year   12 Under 1 Year   12 Under 1 Year   12 Under 1 Year   13 Under 1 Year   13 Under 1 Year   14 Under 1 Year   14 Under 1 Year   14 Under 1 Year   14 Under 1 Year   14 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Under 1 Year   15 Un	ign
	ne Marylani 8e-f show	ctor	10a. State     10b. County     10c. City, Town or Location     10d. Inside City Lim       MD     Prince George's Hyattsville     12c. City, Town or Location     10d. Inside City Lim	
	ath with the 23s or 2	Funeral Director	106. Street and Number 107. Zoth Avenue 108. Zip Code 20782 109. Citizen of What Country? USA	
960	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s. or 28e-f show the Madical Examble: "set be retified at	by	11. Marital Status  1	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene titem 27 is marked other then "neturel", or Items 23s or 28e-f show other treumetic event, the Mcdical Exporter out to pruffling a	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Plumber  16b. Kind of Business/Industry  Construction	
Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other then " treumetic event, the Max	To Be C	17. Father's Name (First, Middle, Last)  Walter Kramer  18. Mother's Name (First, Middle, Maiden Sumame)  Margaret Driscoll	
	s 1 and 2 sho I Health and Item 27 is m other treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Barbara Kramer Spouse 5107 20th Ave., Hyattsville, Md., 20782  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	1
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		1 Burial Accremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Principles Service Line 1  22. Name and Address of Facility  Ullrich Funeral Home Berlin, Md., 2181	_
8760,	The law requires that the death certificate be executed to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the steed for use as the burial-transit to the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the steed for use as the stee	dical Examiner	23a. Path Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death disease or condition resulting in death)  Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	~S
.O. Box 6	it the death certificate be e. by the attending physician tached for use as the buria	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year	
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Starkhov	vn
		e Completed	24a. Was an autopsy performed?    Vernicke's enceptrace path (Check only one)   24b. Were autopsy findings availate prior to completion of cause of death?    25. Was case referred to medical   26. Place of Death (Check only one)   27. Place of Death (Check only one)   27. Place of Death (Check only one)   27. Place of Death (Check only one)   28. Place of Death (Check only one)   27. Place of Death (Check only one)   28. Place of Death (Check only one)   28. Place of Death (Check only one)   28. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check only one)   29. Place of Death (Check onl	le f
ion of Vital	ng Physici fter this cer ineral direc	To B	examiner?  1	
Division	ne Hospitel or Attendi 124 hours after death. 1e Funerel Director: A bletely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in In	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To To	~	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	
	1.5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  IN ISTINE GRIFFIN MD 1209 COASTM HOHLAY, FENNICIC TSLAND,	Œ
	Sta Registr	4	31. Date filed (Month, Day, Year)  AUG 2 4 2004  32. A gistrar's Signature	

page Diractor:

	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the death. Do not enter the mode of one cause on each line.	tying, such as cardiac or res	piratory arrest,	Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Asphyxia			Onset and Death
	resulting in death)	Due to (or as a consequence of):			
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
cal Exar	that initiated events resulting in death) Last	dd.			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (specify 9 Unknown		23d. Date of Month	delivery Day Year
d by Ph	Part II. Other significant conditions co	intributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacco use contribut	e to the cause of death?  Probably 4 □Unknown
Somplete				24a. Was an autopsy performed?	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Be (	25. Was case referred to medical examiner?		26. Place of Death (Ch	eck only one)	
Lo	1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 20XER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 Residence 6 Other (5	Specify)
ertification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Found 8-28-04 Found 4:15 A	Work?	Describe how injury occurred bject was asph	yxiated
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ▼ Homicide determined	28e. Place of Injury - At home, farm, street, factory, official building, etc. (Specify)  Residence	ce 28f. L	ocation (Street and Number of City or Town, State) 8/4 SDy MD	San Mateo Trai

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XMedical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

AUG.

29, 2004

DHMH 17 Rev 1/2001

24 hours a Punaral I

within 2 To tha

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
AUG 3 1 2004

Medical

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Frederick J. Kassakatis 2004 9:15 August 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1985 Fields Road Anne Arundel Jessup If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1XM 2□F Director 212 40 1283 63 Oct 7, 1940 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "naturel", or Itams 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director MD Sykesville Carroll 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 7530 Dogwood Drive 21784 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Specialties Interiors Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! John A. Kassakatis Ida M. Lancaster ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynda Barrett/Personal Repr. f Health 121 Mill Creek Drive Dover, Deleware 19904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Its eny injury or oti ong. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-16-2004 Metro Crematory Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee **∕**M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ANCER 2 month Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as the attending i IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy 1 Live birth Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à pe 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No certificate 1 Yes 2 No 1 Tes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case reterred to medical examiner? sister's Other: 4 Nursing Home 5 Residence 6 Other (Specify) home 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Fo the Hospitet To the Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2004

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**Esgistrar's Signature** 32.

AGNES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D16354

CATON AVE

August 13, 2004

BALTIMORE

			For Stata Registrar	State of	f Maryland		artment rtificate			and Me		giene	004	28	457
	_		Decedent's Name (First, Middle, I	Last)							2. Date of Dea	ath Day	Yea		ne of Death
	Physicia /Medic		Charles Richar	d Kissi	nger						August			1	l:09A M
	Examin		4a. Facility Name (If not institution, g	rive street and nur	nber)		4b. City, To	own, or	Location o	of Death		4c.	County of De	ath	
			Howard County G	eneral H	ospital		Colum					Но	ward		
1	Funeral Director		5. Social Security Number 316-14-9144	.Sex 1X M 2□F	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Months [	Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da 1ay 5,	y, Year)		irthplace (St Country) diana	ate or Foreign
	D .	}	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Insid	de City Limits
	sho	ă			Colv	mbia								1 🗆	Yes 2∑No
	28a-	Director	Maryland Howard		COTO	шота	10f. Zip C	code				10g. Citi	zen of What (	Country?	
	with sa or		6336 Cedar Lane	Apt. 3	53		2104	44				USA			
	leath	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	. 13.	_		spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)		14. Race - An		ın,
(0	r Iter	Funeral	1 Never Married 2 Married	Armed Fo	rces? 2 No				Specify:	1, Риело Р	tican, etc.)		Black, Wh	iite, etc.	
ဗ္ဗ	eft, o	þ	3 Widowed 4 Divorced	Year or D	2□No /e 1943-46 ates:		1 ☐ Yes 25	Z 140	эреспу.				Specify: Wh	ite	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. I Hygiene. I other then "neturel", or liems 23a or 28a-f show avent, the Madical Examiner court by notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual ( kind of work DO NOT use	Occupa done d	tion <i>uring m</i> os	t of workin	ıg	16b. Ki	nd of Busines	s/Industry	
7	ithin len	ig.	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	retired)							
2	ygier ygier n, E	S	47 Fatharda Nama (First Middle 1 s	4		Manag	ement		18 Mothe	ar's Name	(First, Middle,		el Fac	tory	
밀	be fill	Be	17. Father's Name (First, Middle, La									THE CONT	03///4///07		
Maryland	d Mer d Mer narke	မ	Charles Wilmer  19a. Informant's Name/Relationship		r	10b Mailie	ng Address (				ddison Route Numbe	er City o	r Town State	Zin Code)	
Mai	12 st h and 7 Is n traun	1	Susan Kissinger		daughter										7
e,	1 and Healt em 2 ther	1	20a. Method of Disposition	Dibecii	20b. Pla	ce of Dispo	sition (Name	of	1		st 24,		cation - City		
ğ	ages nt of nt of re it		1 Burial 2XXCremation 3		State		natory or other		1	_	04	0de	nton,	Marvla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department		21. Signature of Funeral Service July		, W • 23						Servi				
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			23a. Part1. Enter the disease, or or shock, or heart failure. List or	nly one cause on e	ach line.									Interva	l Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		EKOSC		071C		ARI	SIOV	* CUI	AR	DISTA	-	
н	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):									
н		-	Sequentially list conditions, if any, leading to immediate	b	(or as a conseque	ence of):									
	red	nin	Cause (Disease or injury	7											
<u>,</u>	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to	(or as a conseque	ence of):									
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89	tifica ng ph as th	ledi	15.55141.5												
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant		come of pregnant pirth 2 Petal o	death 3[	∃Ectopic preg					1 2	23d. Date of d Month	elivery Day	Year
О	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of dea own	ath 5	Other (spec	cify)						,	
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	res th					ing in are a	ingonying suc	acc gric		•	_	Yes 2	_		4 <b>√</b> _Unknown
orc	v requir been s should	sted	Congestive Hear	r railur	<u>e</u>						04-146-		045 14/		71
ec	e law has b	Completed					<del></del>				24a. Was autop		prior to death	completion	ings available of cause of
=		S									1 Yes	2√E No	1 🗆 Y	s 2 No	
Ş	ysician: Th	Be	25. Was case referred to medical examiner?	Hospital:				Othe	·-		(Check only o				
of	S S =	7 10	1 ☐ Yes ② No  27. Manner of Death	1	- 1	R/Outpaties 28b. Time o			4 🗆 140	-	ne 5 🗌 Resid			ecity)	
n		ion	1 Natural 5 Pending		of Injury th, Day Year)	Injury	M	c. Injury Work	? ∕es 2 🗖	1			,		
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Division of Vital Records,	after deatl Director: I in by the	Certification;	4  Homicide determin	build:	ing, etc. (Specify)						City or Tov	vn, State	)		
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	To the Ho within 24 To the Fi complete	Medical	29b. Signature and title of certifier		ner stated.				number				e signed (Mo		
	To the within To the compl		250. Signature and title of certifier	1					056	50					
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	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signatu	ite		_ <u> </u>					,		
		ar	AUG 2	o 2004	Modern.	dr.	Coast,	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 8/26/2004 Registrar 10a,b,c,e & f, per f.home, Rag. No. ET WCHD 1. Decedent's Name (First, Middle, Last) Month **Physician** 0502 N 24 2004 VIRGINIA MARIE KASTNER /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) Examiner Salisburg Regions Medical Center Wiconico eninsula tf Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Min. Months Hours 1 M 20 F Director <u>3/22/1920</u> 136-16-7890 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic event, the Madical Exampler must be multified at Southampton Ocean Pines NJ Burlington 1X Yes 2 No Director MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 08088 Andover Ct. 1135 Ocean Parkway 21811 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) 12 Law Librarian Insurance Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental Fise marked of Joseph Weber Minnie Leedecke P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f of Health 39 Boston Dr. Ocean Pines, MD Allan Kastner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 8/24/04 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE Cape Henlopen Crematory 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service License 108 William St. Berlin, MD 21811 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ACO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner certificate be executed use as the burial-transli Due to (or as a consequence of): Box 68760 physician IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 10 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tntury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature D. 15006 2004 Mohan R. Bhat M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O.H. 8 DRIVE TERN SHORE 614-B 32. Algistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 4 2004 Registrar

			1 - For State Registrar	State of Marylai		artment o			nd Menta		ene		291.50
	Physici	an	1. Decedent's Name (First, Middle	Listo.					Mo	te of Death	Day	Year	3: Time of Death
	/Medic	al	James 4a. Facility Name (If not institution		~	4b. City, Tov	wn orto	ocation of		UCUST	4c. County of	200+	7:00 AM
	Examin	er	College View Ce			Freder		JOE HOLL OF	- Douth		Freder		
	Funeral Director		5. Social Security Number 220–16–0549	6. Sex 1 △ M 2 □ F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Y Months D		f Under 2 Hours	Min. 8. Dai Min. (Mo May	te of Birth onth, Day, Y	925	9. Birthpla Countr Mary	ce (State or Foreign Land
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10	d. Inside City Limits
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	ith tha	Direc	10e. Street and Number	. D 1		10f. Zip Co					. Citizen of W		-
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39	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-f show the Medical Evantinal must be notified at	by Funeral Director	1 Never Married 2 Marri 3 XWidowed 4 Divorced	Armed Forces?		If Yes, specify  1 ☐ Yes 2 ☒	Cuban, I	Mexican, Specify:	Puèrto Rican,	etc.)	Black	white, et White	tc.
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121	within ane. than *	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	Custo		etired)			P	ublic S	Schoo	1 System
	d ba filed antal Hygic cad other c event, II	To Be Co	17. Father's Name (First, Middle, I Joseph Liston	Last)			18		's Name <i>(First,</i> ie John:		uiden Sumame	e)	
Maryland	and 2 should I Balth and Men n 27 Is marka Per traumatic	1	19a. Informant's Name/Relationsh Donna Liston /		19b. Maili 9314	ng Address (Si Rocky	reet and Ridg	d Number ge Ro	or Rural Route ad Rocl	Number C ky Ric	ity or Town, Sige, MD	State, Zip C	Pode) 78
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural; or items 23a or 28a-f show amy injury or other traumatic event. The Medical Examinat must be notified at Once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State	cemetery, cre	osition (Name of matory or other n Mem.	r place)	8	Date 5-26-04		ederic	-	
Balti	permit. Departmitmporta any inju		21. Signature of Funeral Service I	Licensee	1	2. Name and A 04 East	Mai	of Facility in St	Stauff treet,	er Fui Thurmo	neral H ont, MD	Home ) 2178	38
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Divisi	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be		reet, factory, of			28f. Loc	cation (Street) or Town, S	et and Number State)	r or Rural I	Poute Number,
	To the Hospital or Attending Physician: Tha I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C		g Physician: To the best of my kn Exeminer: On the basis of examin and manner stated.									
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	iD		30. Name and address of person	who completed cause of death (Ite	m 23a) (Type,	Print) 7	FR	TOL	= 100 210%	HD	1105-	170	f
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			Registrer  1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea	ath	O 17 74	3. Time	of Death
	Physici		Laura	Inez	Lewi	S			A	Month ugust	20.		1:55	РМ
u .	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Town, or	Location of		-6=	_	County of D		
		•	Millenium Health &	& Rehab		1	estvi				Pr.	ince G	Georges	
	Funeral Director		5. Social Security Number 6. Se 092–44–6806	7. Age	e (In yrs. last birthday 94 Yrs.	Months Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day 1/01/1	v. Year)		Birthplace (State Country) renada	or Foreign
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	show	_	10a. State 10b. County	,	10c. City, Town or L									s 2 No
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	ns 23	erai	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Dece	dent of Hi	spanic Origi	in? (Specif	y Yes or No-			American Indian,	
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Physicia /Medic		Decedent's Nam	ne (First, Middle, i		LES				2. Date of D Month AUG .	D	ay Year , 2004	3. Time of Death
Examin			-	give street and numi				or Location of Death	1		c. County of Dea	
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ral tor		5. Social Security N 249-52-3 Usual Residence of	3428	.Sex 7 1⊠M 2□F	66	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, D	ay, Year	r) Co	thplace (State or Foreign ountry) Columbia SC
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any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	DC 10e, Street and Nu	Imher		Wa	shingto	10f. Zip Code			10a. C	itizen of What Co	1√2 Yes 2 □ No
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2	To B	Isaiah	Lyles					Celia	Ann Wat	kins	5	
arine.		19a. Informant's N					ng Address (Street					Zip Code)
			Lee Lyles	s /Wife	205		1 T St. S	S.E. Wash	ington Date			Town Ctata
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	1	For State Registrar	State of	Marylan		artment <i>tificate</i>			ınd Me	ental Hyg	iene	004	28462	
		1. Decedent's Name (First, Middle, Las							2	2. Date of Deat	h Day	Year	3. Time of Death	
Physicia /Medica		Robert J. I	ambert,	Sr.						AUGUST	31	2004	2:23PM	
Examine		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City,	Town, or	Location o	f Death			ounty of Death		
		Doctor's Communi	ty Hosp	ital 7. Age (in yrs.	last highday)	Lanh		If Under 2	24 Hrs. I s	. Date of Birth	Pri	nce Geo		
Funeral Director	5		M 2□F	7. Age ( <i>m</i> y/s.	Vre	Months	Days	Hours	Min.	(Month, Day,			place (State or Foreign htry) nond, Va.	
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arylar show	<u>.</u>	10a. State 10b. County			y,TownorLo Mitchel		م1						0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
the Marylar 28a-f show	Q L	Maryland   Prince (	eorges		mittine.	10f. Zip				1:	Da. Citizer	n of What Cour	ntrv?	
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1215-0036 within 72 hours atter death with the Maryland ene. then "neturet; or Items 23e or 28a-f show he disal Examiner must be rivilitied at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	45-1	(Give	kind of wor DO NOT us	rk done d se retired,	luring most )		7				
nd 2121 e filed within al Hygiene. I other then went, the Me	mo.	Elementary/Secondary (0-12)	College (1	-40f 5+)	Res	spira	tory	Ther	apist		Fede	ral Go	vernment	
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laryla 2 should and Men is marke eumatic		19a. Informant's Name/Relationship (	Type, Print)							Route Number				
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0 00		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify			amatani arai	natani ar al	that place	ParkA		,2004		-		
Baltimo		21. Signature of Funeral Service Licer	mio A	10/085	- 1	. Name an A1exa 5538	nder Mari	boro ^P	Pike/	uneral Forest	Home	s, P.A	•20747	
*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the dear	th. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between	
Pnysician	.	Immediate Cause (Final disease or condition	C	ovon	any 1	inter	4	Dise					Onset and Death	
/Medical Examiner		resulting in death)		or as a consec	quenus f):	reuz	1							
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Division of Vital Records, P.O. Box 61 To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		irth 2∏Feta ant at time of c	2   Fetal death   3   Ectopic pregnancy   sat time of death   5   Other (specify)						23d. Date of delivery Month Day			
S, P.O. es that the de	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D									id tobacco use contribute to the cause of death?			
rds quires and be	ed by									1 □ Y€	s 2 🔯 l	No 3□Prob	pably 4 □Unknown	
Division of Vital Records, or Attending Physicien: The taw requires tafter death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	Completed	24a. Was an autopsy prior performed? deal										24b. Were auto prior to co death? 1  Yes	opsy findings available mpletion of cause of	
f Vital Re ysicien: The properties of director, page	0	25. Was case referred to medical						26. Place	of Death	Check only on		12.00	2310	
of Vi	To B	examiner? 1 Tes 2 No	Hospital: 1 🔲	Inpatient 2	ER/Outpatier	nt 3 DC	Othe	9r: 4 🗌 Nu		e 5 🗌 Reside			(y)	
Jn O' ding Ph After th funeral	ou:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work	ς?		3d. Describe ho	w injury a	occurred		
Visio	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place	of Injury - At h		M reet, factory		Yes 2 □ I		8f. Location (St City or Town	reet and h	Number or Rura	al Route Number,	
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Division or treatment or the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examone)		best of my kn asis of examin ner stated.	owledge, deat ation and/or in	vestigation	, in my or	oinion, dea	u piace, ar th occurred	at the time, d	ate and pl	ace, and due to	o the cause(s)	
To t To t com	Σ	29b. Signature and title of certifier  Jeffer / C	eus	en A	20	290	E. License	number 194	144	, 2	9d. Date s	signed (Month, 34/04	uay, Year) /	
CR (15)	)	30. N me and address of person who SEVEN 5. REAL	completed caus	se of death (Ite	m 23a) (Type,	Print)	5017	E 35	16	AUREL	nd.	2070	7	
Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 6 200	4 Kes	legistrar's Sign	ature dos	W								

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8 20 McGREGOR 2004 10:00 A^M WALLACE WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ocean City 701 Rusty Anchor RD Unit 17 Worcester If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 ☐ F 1/23/1927 579-24-7320 Washington, DC **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or Items 23a or 28e-f ehow adical Examiner must be notified at XXes 2 No Funeral Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Rusty Anchor RD Unit 17 21842 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, in a Medical Examiner mutal once. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII White 1 ☐ Yes 2 XNo Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy C. Walters John F. McGregor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Rusty Anchor Rd., Unit 17, Ocean City, Md. 21842 Lenora McGregor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Cape Henlopen Crematory -23-04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Frankford, Delaware 22. Name and Address of Factine Burbage Funeral Home 108 William St. Berlin, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UN 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1. Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irrector, page 2 s autopsy performed 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) b 2 1 Tes 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death 28b. Time of Certification: ► Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: , d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29c. License number 29d. Date signed (Month, 29b. Signature and title of carrier Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2.H. 10+1 8324 OCEAN 020

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

AUG 2 3 2004

Registrar's Signature

		1	State of Maryla  State of Maryla  For State of Maryla					2001	28464	
			1. Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic	ai	Vera Hope Merritt			/	+ugust			
	Examin		4a. Facility Name (If not institution, give street and number)	111	4b. City, Town, or Loca	ation of Death	•			
			5. Social Security Number 6. Sex 7. Age (In yrs	s, last birthday)			B. Date of Birth	9. Birt	hplace (State or Foreign	
	Funeral Director		2 8-24-39 0 1□ M 2 X F 74	, Yrs.	Months Days Ho				MD	
	D		Usual Residence of Decedent	Din. Town and					10d Inside City Limits	
	anylan show	_	Tou. State						1 ☐ Yes 2 No	
	he Ma	Director	MD Worcester S  10e. Street and Number	now Hi			100	. Citizen of What Co	ountry?	
	with t	直	4441 Bayside Rd.					US		
	ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispani	ic Origin? (Spec	ify Yes or No-	14. Race - Ame		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, the Mardical Exall in or must be notified at	by Fur	1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	pope Merritt pive street and number)  ### Ab. City, Town, or Location of Death ### Ab. City, Town, or Location of Death ### Ab. City, Town or Location of Death ### Ab. City, Town or Location of Death ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Town or Location ### Ab. City, Tow						
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lar)	2 should and Miles mark		19a. Informant's Name/Relationship (Type, Print)						Zip Code)	
	1 and 2 Health tam 27 i		Jeffrey A. Merritt, Sr.		·				Town, State	
Baltimore,	permit. Pages: Depertment of H important: if its any injury or of		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	matory or other place)	0.25		,		
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<u>α</u>	that the ed by detac		Part II. Other significant conditions contributing to death but not r	resulti <i>n</i> g in the ι	ınderlying cause given in	Part I.	23e. Did toba	cco use contribute to	o the cause of death?	
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$\alpha$	The age	шо					performe	ed? death?		
Vital	sician: 1 certifical irector, p	BeC	25. Was case referred to medical examiner?		26.	Place of Death				
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ū		on:	14 Natural 5 Pending (Month, Day Year)	of 28c. Injury at Work?	t 28d. Describe how injury occurred					
Sio	Attending or death.	Icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - Al	t home farm et			8f Location (Stre	et and Number or R	ural Route Number	
Division	i or Attend after death Director:	Certification:	4 Homicide determined building, etc. (Spe		reet, factory, office		City or Town,	State)	3147 10410 174111001,	
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	ne Ho n 24 t ne Fu sletely	Medical	(Check only one) 2 Medical Exeminer: On the basis of exam and manner stated.	ination and/or in	nvestigation, in my opinio	n, death occurre	d at the time, dat	e and place, and du	to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	20	29c. License nun	mber	290	d. Date signed (Mon	h, Day, Year)	
•				- 0	100-	1/10	0	723/0	4	
i	1 ~		30. Name and address of person who completed cause of death (I	tem 23a) (Type	, Print)	10.1	1 7	· ·	•	
, ,	1.0		Simona Eng Peninsule Kesion 31 Date filed (Month Day Year). 32 Registrar's Sic	al Med	. Center DA	lisburg	mad	180		
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 4 2004	H A	29c. License nun  #/00  Print)  Center SA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 18, 1:05 A M Stephen Richard Mayer August 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County 225 Langley Lane Solomons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16, 1947 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 1**⊠**M 2□F 217-46-7443 57 Maryland Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Itams 23a or 28e-f ehow 1 ☐ Yes 2 No Director MDCalvert County Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20038 U.S.A. 225 Langley Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status flled within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Heatilt and Mental Hygiane. Important: if item 27 is marked other than eny injury or other trainmeth. College (1-4or 5+) +1 Elementary/Secondary (0-12) Business Consultant Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Mayer Frances Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5038 Harvard Street, St. Leonard, Maryland 20685 Brian Lee Mayer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete August 21. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Solomons, Maryland * 4 ☐Donation 5 ☐ Other (Specify) Solomons Cemetery 2004 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licenses Michael W. Lee 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** eNX resulting in death) /Medical Due to (or as a consequence of) Examiner 62 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year detached for 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 2 16 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 🗌 Yes Certification: To 4 ☐ Nursing Home 5 y Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00255 August 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14090 Solomons Island Road, Solomons, MD 20688 J. John Barth. III., M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 0 2004 Registrar

			for State Registrar	State of		nd / Depa	artmen rtificat				lental Hyg	jiene	004	28466
	Dhi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio	al	Teresa Grace								August	23,	2004	11:00A M
	Examin		4a. Facility Name (If not institution 121 Second Sta		nber)				Location of	of Death			County of Death	
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	Funeral Director		5. Social Security Number 173–14–4047  Usual Residence of Decedent	6. Sex 1 M 2 F	93	. last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day 5–13–1	911	Pen:	place (State or Foreign intry) nsylvania
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Macked Exal after hits be mailled at	to	Pennsylvania Blair Altoona											1 ☐ Yes 2 🔀 No
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Maryland 21215-0036	hour tural		15. Deceden	Year or Da	ites:	16a. Dece	dent's Heus	I Occupa	tion			16h Kin	d of Business/Ir	odustav
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lan.	s 1 and 2 should be f f Health and Mental P item 27 Is marked ot other traumatic eve		19a. Informant's Name/Relations	hip (Type, Print)			-				al Route Numbe			p Code)
	s 1 and of Health item 27 other tr		Anna Miller/ Da	aughter	1						nnapolis	<u> </u>		
Baltimore,	8°= 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ⊠Removal from	State 20b.	Place of Dispo cemetery, crei	nsition (Nam matory or o	ne of ther plac	9)	ı	Date	20c. Loc	ation - City or T	own, State
Ë	nit. Pagartment ortant: injury		`4 □ Donation 5 □ Other (S	pecify)		alvary	Cemet	ery	1	8–24	-04	Alto	oona, Pa	A
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee		22	2. Name an	d Addres	s of Facilit	^{ty} Geo	rge P.Ka	las	Funeral	L Home
	20244		23a Part 1 Enter the disease or	complications that o	aused the dea	th. Do not ent	9/3 S		ons .	<u>Isla</u>	nd Road,	_Ed{	gewater.	Md.21037 Approximate
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Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy									2:	3d. Date of deliv Month	ery Day Year
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	g Phy erthi	F	27. Manner of Death	28a. Date of		28b. Time of		8c. Injury Work	at	arsing ric	28d. Describe ho	ow injury	occurred	⁹⁹ He me
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Division	tal or Attendii s after death. al Director; A ed in by the fu	Certification:	3 Suicide 6 Could determ	ined 286. Place	of Injury - At h	nome, farm, str	eet, factory	, office			28f. Location (St City or Town	reet and n. State)	Number or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b.	Cer		. 1										
	Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medical	g Physician: To the Examiner: On the ba	isis of examin	owledge, deatl ation and/or in	occurred vestigation,	at the tim	e, date an inion, dea	id place, ith occurr	and due to the cared at the time, d	ause(s) a	and manner as solace, and due to	stated. o the cause(s)
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			20 Normand and and and and and and and and and	ubo completed as	n of death //:	m 22c\ /7 -	Deine)	U 3	, 0	1			, , -3, .	,
			30. Name and address of person	1	or death (ite		i i	An	140	· lis	MD	214	0) .	
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	Sta	ite	31. Date filed (Month, Day, Year)	4 2004 32. P	sistrar's Sign	ature	1 :							

		•		ate of Maryland	/ Depa		lealth and M	lental Hygi	_	04	28467		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  IVENE E. MCO	re				2. Date of Death Month Aug.	Day 18	Year 2004	3. Time of Death		
	Examin		4a. Facility Name (If not institution, give street Howard County General	Hospital		Colu	r Location of Death	J		oward			
	Funeral Director		5. Social Security Number	17. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 9,			ace (State or Foreign ry) rland		
	death with the Maryland ms 23a or 28a-f show rmust be rollified at	ctor	10a. State 10b. County MD Howard		Town or Lo					10	ld. Inside City Limits 1 ☐ Yes 2 ☑ No		
	vith the	Director	10e. Street and Number			10f. Zip Code 21042	2	10	-	What Count	-		
	eath v	Funeral	3109 Paulskirk Drive	as Decedent Ever in U.S.	. 13. V		dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Ra	ed Sta	ın Indian,		
		by	1 Never Married 2 Married 1	med Forces? ☐ Yes 2 ☐ No Yes, Give ear or Dates:		f Yes, specify Cub 1 ☐ Yes 2€ No		Rican, etc.)	Black, White, etc.  Specify:  White				
7-017	within 72 hours after ene. then "natural", or ita	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)		(Give life. L		pation during most of work d)	ing 1	6b. Kind of E	Business/Ind	ustry		
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yiand		To Be	Oscar Shaffer  19a. Informant's Name/Relationship (Type, P	local [	10b Martin	an Address /Stroot	Elizabet	:h	unknov	wn	Code		
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ds, P.	requires that the reen signed by th hould be detache	þ	Part II. Other significant conditions contribu	ting to death but not result	ven in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ €nknown							
Vital Record	The lavite has	Completed				24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 No							
<u>=</u>	cien: ertifica	Bec	25. Was case referred to medical examiner?					h (Check only one	2				
ō	Phy this ral d	2	1 ☐ Yes 2 ☑ No Hospii	1 Impatient 2 LE	R/Outpatier 28b. Time of Injury	Time of 28c. Injury at 28d. Describe how injury occurred							
DIVISION	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	a Could not be	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (Str. City or Town,	Street and Number or Rural Route Number, wn, State)				
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination and manner stated.				red at the time, da	te and place	, and due to	the cause(s)		
1	To the within 2 To the Complet	Ž	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date sign	ed (Month, D			
	(2)		30. Name and address of person who comple	ated cause of death (Item)	23a) (Type,	Print)  Lixed (ki	Cale	mbia Mi	Do	10.101	2007		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Signatu	Ire	urein the	my, will	MAIN 101	V, C	1099			
	Regist	rar	AUG 2 0 2004	Moleve	O. 1.	banker							

Physicia:		1 - State 8-31-04 Amend #1	D D D D T TT								2. Date of De		<b>UU</b> 4	3. Time of Death	
/Medica	al .	HAZEL			MCKAY						August	23	2004	12:15 P	
Examine	er	4a. Facility Name (If not instituti MONTGOMERY (	_				4b. City,		Location of	of Death			County of Dear		
Funeral		578 38 5666	6. Sex		Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Bir	th	ONTGOMI 9. Bin	LKY thplace (State or Forei ountry)	
Director		<del>579-07-4189</del>	1 🗆 M	2 <b>X</b> F	7	7 Yrs.	Months	Days	Hours	Min.	(Month, Da May 2		927 Mar		
*	}	Usual Residence of Decedent  10a. State 10b. Coun	tv		10c. City	, Town or Lo	cation							10d. Inside City Limit	
28a-f show	ō													1 X Yes 2 N	
or 28a	irec	10e. Street and Number 10e. Street and Number 20.706										10g. Citi	zen of What Co	ountry?	
naturel', or items 23e or 28e4 show	by Funeral Director	7938 Fiske Avenue 20706  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig											S.A.		
items filer	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Ma	A	Vas Decede Amed Force □ □ Yes 2	es?	S. 13.	Was Deced If Yes, spec	ent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, Whit</li> </ol>		
of, or	by F	3X Widowed 4 □ Divorce		f Yes, Give Year or Date			1 ☐ Yes	2₽ No	Specify:				Specify: }	31ack	
netur lical l	Completed	15. Decede (Specify only high	ent's Education	n mpleted)		16a. Dece	dent's Usua	al Occupa	ation furing mos	t of work	in <i>a</i>	16b. Kii	nd of Business	/Industry	
han .	mpie	Elementary/Secondary (0-12		College (1-4	or 5+)		kind of wor DO NOT us		)		9				
Hygie Sther I		12th 17. Father's Name (First, Middle	e, Last)			Hon	ne Mal	cer	18. Mothe	er's Name	e (First, Middle	Private  dle, Maiden Sumame)			
h and Mental Hygiene. 7 is marked other than " raumatic event, Ire Man	To Be	Marion Ha	irris							iola	,	Craw	,		
s mai		19a. Informant's Name/Relation	nship (Type, I	Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City o	Town, State, 2	Zip Code) 20740	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, IT e. M. once.	3.	Gary	МсКау	/Son	205 2				e Ave					rk Marylan	
or of		20a. Method of Disposition  1   ■ Burial 2 □ Cremation		val from Sta	ate For	lace of Dispo emetery, crea Linc incoln	natory or o	ne or ther place <b>:em -</b>	9)		Date		cation - City or		
artmer ortant injury	1	'4 □Donation 5 □Other  21. Signal re of Funeral Service					Ceme 2. Name an							Md. aryland	
Depa Impo any ir		1	Consoci	/						J .	B. Jen			.1 Home d 20785	
		29a Parti. Enter the disease, shock, or heart failure. Li	or complication	ms that cau	sed the death								icir y rain	Approximate Interval Between	
ysician	1	Immediate Cause (Final disease or condition			rdial	Infarc	tion							Onset and Death	
Medical caminer		Due to (or as a consequence of):													
	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Diabetes  Due to (or as a consequence of):  Congestive Heart Failure													
ansit	Examiner														
an an	Exa	resulting in death) Last Due to (or as a consequence of):													
physician and the burial-transit	lca	d													
attending phase as the	Physician/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy									24 5 (4-)				
atten for u	cian	250. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D										2	3d. Date of del Month	ivery Day Year	
by the tached	hysi														
	by P									23e. Did t	d tobacco use contribute to the cause of death?				
been si	ted										10	Yes 25	No 3□Pr	obably 4 Unknow	
2 2	Completed										24a. Was autor	osy	prior to d	itopsy findings available completion of cause of	
certificate												rformed? death?			
recto	o Be	25. Was case referred to medic examiner?	Hospi	ital: 1 🗆 Inn	nations WEI	ED/Outration		Othe			(Check only o		<b>To:</b> 10		
eral de	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	21	8a. Date of	Injury	ER/Outpatier 28b. Time of		8c. Injury Work	4 LI NU		me 5 Resident			cify)	
r death. sctor: After by the funer iffication:	atio	E . Hooldon	stigation	(MONIA,	Day Year)	Injury	М		? /es 2 □ i	No					
after death	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined	Be. Place of building	Injury - At ho , etc. (Specify	me, farm, str	eet, factory	, office		1	28f. Location (S City or Tox		Number or Ru	iral Route Number,	
re at										ļ.					
within 24 hours after To the Funerel Dir. completely filled in I Medical Cert	dica	29a. Certifier 1 Certify (Check only 2 Medic	al Examiner:	<ul> <li>n: To the be On the basi and manner</li> </ul>	is of examinat	wledge, deati ion and/or in	occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
24 hours Funerel stely filled	ĕ	29b. Signature and title of certif		arro maririo	, statod.		29c	. License	number			29d. Date	signed (Mont)	h, Day, Year)	
within 24 hot To the Fune completely fil	Σ							. I M	1 411	^		0	10111.	1	
he ple	2	> KWV	Cathe				1)	11	(M)V	/		X	12410	4	
within 24 hou To the Fune completely file	2	30. Name and address of person	on who comple	eted cause	of death (Item	23a) (Type,		47	404			8	124/0	4	
within 24 hou within 24 hou To the Funer Completely fill		30. Name and address of persons Sobhan Mather 31. Date filed (Month, Day, Yea	ws M.I	). 30		chell	Print)		401	ie,	Marylan	nd 20	716	Ψ	

			For State Registrar		State	of Mar	yland / [	•	nent of H		nd Me	_	giene Reg. No.	004	28469
	Physicia		1. Decedent's Nam	e (First, Middle	0 1	sh					-   -	2. Date of De. Month		Year /	3. Time of Death
	/Medic Examin		4a. Facility Name ( Atlanti	c Gen	eral He	Spi	tal	ĺ	City, Town, or Serlin	, Mo	vyl	and	W	unty of Death	
	Funeral Director		5. Social Security N		6. Sex 1 ☐ M 2 ☑ ¥F	7. Age (	(In yrs. last bii 91		Under 1 Year onths Days	Hours	Min.	B. Date of Birt (Month, Da 3 – 22 –	th ly, Year) -13	9. Birthp	place (State or Foreigh ntry) ILLinois
	ryland how		Usual Residence o	10b, County		1	10c. City, Tow							1	0d. Inside City Limits
	ith the Marylan or 28e-f show	ector	Md.	Worce	ster		0cean		Y Of. Zip Code				10a. Citizer	of What Cour	1. EYes 2 □ No
	N with	ID I	617 Bay		drive					1842			US.		,.
336		by Funeral Director	11. Marital Status 1 ☐ Never Man 3 ☑ Widowed	ied 2 Marri	12. Was De Armed 1   Yes If Yes, 0 Year or	Forces? 2.53.No Bive			Decedent of H s, specify Cuba Yes 2/X/No	lispanic Originan, Mexican,  Specify:	in? (Spec Puerto R	ity Yes or No ican, etc.)		Race - Americ Black, White, ecify: White	etc.
Maryland 21215-0036	within 72 hours ane. then *natural', the Medical Ext	Completed	Elementary/Seco		grade completed	d) (1-4or 5+)		(Give kind life. DO l	s Usual Occup of work done o NOT use retired	during most o	of working	g		of Business/In	
421	e filed will Hygien other th	Con	1.2 17. Father's Name	(First. Middle, L	ast)			Sare	sperso		's Name /	(First, Middle,		vertis	sing
<u> a</u>	2 should be fi and Mental H is marked ot raumatic ever	To Be	Samue1									th Mi			
Mary	12 sho h and h is ma rauma		19a. Informant's N						ddress (Street						
Baltimore, I	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trac		Delores  20a. Method of Dis  1 Burial 2  4 Donation	position Cremation	3 □Removal from		20b. Place o cemete	f Dispositio ry, cremato	ry or other plac	(8)	Da	te	20c. Locat	Ma., ion-City or To Sbury,	
3altir	permit. F Departme Importer any injur	1 5	21. Signature of F				Salis		Crema me and Addres			20	Dari	sbary,	riu.
	40280		23a. Part . Enter	the disease, or	complications tha	t caused th	ne death. Do		rich F e mode of dyin					in, Mo	Approximate
	Physician		Immediate Cause disease or conditi	(Final	only one cause or	2PS	15							(	Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due t	o (or as a	consequence	of):	+ 10	rfec-	to 0				V
-1913 19006-	P :	Iner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or	onditions, nmediate entying	b. Due t	o (or as a	cons u-nce	of):			1,0				
~ 42 -	be executed iician and burial-transit	Examiner	that initiated event resulting in death)	S	c	o (or as a	consequence	of):			·				
800	ate hys				d										
0.0.B Expired .O. Box 6	death e atter d for u	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	months?		birth 2 gnant at tir	pregnancy □Fetal death me of death		opic pregnancy er (specify)	,			23d	. Date of delive Month	ery Day Year
rds, P	es pe pe	by	Part II. Other signi	ficant conditio	ns contributing to	death but	not resulting i	n the under	ying cause giv	en in Part I.			obacco use Yes 2 🗆 N		ne cause of death?
Chris	The law requir ate has been si page 2 should	Completed	DAP	u fi	bulla	cho					_			prior to co	psy findings available mpletion of cause of
/ital	cien: 'ertifica	BeC	25. Was case refe examiner?	rred to medical		- 5					of Death (	Check only o			
Jag no	Attending Physicien: r death. ector: After this certific by the funeral director.	lon: To	1 Yes 2 2 27. Manner of Dea 1 Natural		28a. Dat (Mo	Impatient e of Injury onth, Day		Time of	DOA Cthe 28c. Injun World	4 LINUIS	28	e 5 🗌 Resid		Other (Specificourred	у)
Division	in Sire	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could n determi	ot be 28e. Pla	ce of Injury Iding, etc.	y - At home, fa (Specily)			750 2 3.11		3f. Location (5 City or Tox		umber or Rura	I Route Number,
_	Hospite 4 hours Funeral	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	g Physician: To t examiner: On the and ma	he best of basis of e anner state	xamination ar	e, death occ nd/or investi	curred at the ting gation, in my o	ne, date and pinion, death	place, an	nd due to the d d at the time,	cause(s) and date and pla	d manner as si ice, and due to	tated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and	title of certifier	o Sk	4/8	en, e	10	29c. License	006	195	(QE)	29d. Date si	gned (Month,	Day, Year)
CL	1.4		30. Name and add	NE GR	(FRN)	10		(Type, Prin	TAR H	61th A	4, F	ENU	CKI	SCON	), DE 1994,
	Sta Registr		31. Date filed (Moi	AUG 2	2004	egistrar'	s Signature	Goe	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa						

		DONALD E •	oates			_		2. Date of De Month AUGUST	ath Day		3. Time of Deat 8:15 A		
/Medical Examiner	4.	a_Facility Name (If not institution, gi 319 CENTRAL AVE	ve street and number,	)		4b. City, Town, FEDER	or Location of	Death	4c. County				
Funeral Director	2	. Social Security Number 6. 295-82-8761  Jaual Residence of Decedent	Sex 7. A 1 <b>X</b> M 2 □ F	ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 02-02-	th 1971	Countr	ace (State or Fon y) Jersey		
-f show fied at	1	Oa. State 10b. County Maryland Carol:	ne	1	Town or Lo					100	d. Inside City Lin		
at be rotified at Director	1	0e. Street and Number 319 Central Ave				10f. Zip Code 21632			10g. Citizen of US	What Countr	y?		
it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at To Be Completed by Funeral Director		Marital Status     Never Married 2 Married     Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1∑ Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Decedent of f Yes, specify Cub 1 ☐ Yes 2 No	oan, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rad Blad Specifi	ee - American ck, White, et whi	tc.		
lygiene. her than "naturi it, the Madical Is Completed		15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	ducation ade completed)  Coltege (1-4or	5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most o	of working	16b. Kind of B	usiness/Indu	istry		
Mental Hyg arked othe atic event, To Be C	1	7. Father's Name (First, Middle, Las Vernon D. Oates						s Name (First, Middle, nerine Sch		ne)			
of Health and I item 27 Is me r other traums	1	19a. Informant's Name/Relationship (Type, Print)  Ashlie Oates - wife  21182 Marsh Creek Rd, #E13, Preston,  20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of certafted, frematory of other place)  20c. Location Company of other place)  20d Fe11ows Cemetery  20d 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow											
Department of He Important: If iten any injury or oth once.	2	0a. Method of Disposition 1	Date 9/01/04		-	n, State							
Departmen Important: any injury once.	2	21. Signatura di Funerell Service tice John A. Crans	11/11/11/11	_		Name and Addre ranston P O Box		al Home eaford, DE	19973				
Medical Medical xaminer		disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate are the body of a cause (Disease or injury	b. Due to (or as	a conseque	ence of):	And The							
physicia the bur dicai		Cause (Disease or injury hat initiated events esulting in death) Last	cDue to (or as	a conseque									
physicia the bur dicai		nat initiated events	c	of pregnan	ence of):  cy death 3	Ectopic pregnanc Other (specify)	у			Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  24b. Were autopsy findings available prior to completion of cause of			
physicia the bur dicai	li 2	F FEMALE:  23b. Was decedent pregnant in the past 12 months?	d	of pregnan 2 ☐ Fetal c t time of dea	ence of):  cy death 3  ath 5	Other (specify)		23e. Did to	bbacco use contr	nth Di	ay Year		
physicia the bur dicai	II   2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions	d	of pregnan 2 ☐ Fetal c t time of dea	ence of):  cy death 3  ath 5	Other (specify)	ven in Part I.	24a. Was a autop perfor	obacco use control (es 2 No  an 24b. V sy med? 2 \( \text{No} \)	ibute to the  3 Probab  Vere autopsylifor to compleath?	cause of death		
physicia the bur dicai	11 2 P	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  art II. Other significant conditions	23c. If yes, outcome 1	of pregnand 2 Fetal of time of deal out not result ent 2 E	ence of):  cy death 3 ath 5 ting in the ur  R/Outpatient 28b. Time of Injury	Other (specify)  identying cause give  3 □ DOA Other  28c. Injury Wo	ven in Part I.  26. Place of	24a. Was a autop perfor 1 XYes Death Check onl or ng Home 5 Resid	obacco use contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of	ibute to the 3 Probab  Vere autops; rior to compleath?  PYes 2[  or (Specify)	cause of death  cause of death  ly 4 Dunkne  y findings avail  letion of cause  No  SCENE		
death.  too: After this certificate has been signed by the attending physicia y the funeral director, page 2 should be detached for use as the but fication; To Be Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  art IJ. Other significant conditions  5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigatic determined 4 Homicide 6 Could not determined	Hospital: 1   Inpatition   28a. Date of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month, Date   28a. Place of Injury (Month), Date   28a. Place of Injury (Month), Date   28a. Place of Injury (Month), Date   28a. 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04-05532 VERNON OATES WHM

Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item#23a 27, 28a-f, per Mc C835 9/21/04 TT
State of Maryland / Department of Health and Mental Hygiene

	1- State Registrer Amend item # 1	Certificate of Death	Reg. No.	28471
Physician	Decedent's Name (First, Middle, Last)     VERNON D. OATES JE	R	2. Date of Death  Month AUGUST 27, 2004	3. Time of Death 8:15 A
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 319 CENTRAL AVE	4b. City, Town, or Location of Death FEDERALSBURG	4c. County of Death CAROLINE	
Funeral Director	214-98-6123 1XM 2□F 39	(In yrs. last birthday) Yrs.  If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	_ (Month, Day, Year)   Cou	place (State or Fore ntry) NSylvania
land land	Usual Residence of Decedent           10a. State         10b. County         1	10c. City, Town or Location		10d, Inside City Lim
Mary Mary Mary Mary	Maryland Caroline	Federalsburg		1 <b>X</b> Yes 2 □
r items 23e or 28e-f showning real from the rust be notified at Funeral Director	10e. Street and Number 328 E. Central Ave	10f. Zip Code 21632	10g. Citizen of What Cour US	ntry?
by by	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ev Amed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - Ameri Black, White, Specify: Whit	etc.
natur dical	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/In	ndustry
than "u	Elementary/Secondary (0-12) College (1-4or 5+)	Manager	Furniture F	Rental
h and Marital Hygiene. Tis marked other than "natural raumatic avant, the Medical E	17. Father's Name (First, Middle, Last) Vernon D. Oates Sr	18. Mother's Name	e (First, Middle, Maiden Sumame) ne Schimmel	
mark mark imati	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City or Town, State, Zi	p Code)
alth a 27 is	Catherine Shaffer - mother	709 Washington Ave, S	eaford, DE 19973	
nent of He net: If item rry or othe	20a. Method of Disposition 1	20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery 09/0	Date 20c. Location - City or To 21/04 Seaford, I	
permit. raggs Department of telepartment of telepartment in ite any injury or of	21. Signature of Fundal Septice Lichtsee  John A. Cranston	22 Name and Address of Facility Cranston Funeral H P O Box 967, Seafo		
nysician /Medical Examiner		he death. Do not enter the mode of dving, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
executed an and rial-transit  Examiner	cause. Enter Underlyin Cause (Disease or injury that initiated events c.	consequence of):		
ertificate be ing physicia e as the bu	d.			
to the death certific dby the attending pletached for use as I Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3 Ectopic pregnancy	23d. Date of deliv Month	ery Day Year
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or Attending Physician: The law requires that the death ca later death. Director: After this certificate has been signed by the attendi in by the funeral director, page 2 should be detached for use strification: To Be Completed by Physician/I			24a. Was an autopsy performed?  11 Yes 2 \( \subseteq \) No 1 \( \subseteq \) Yes	opsy findings availa impletion of cause
iclan: The certificate rector, pag	25. Was case referred to medical	26. Place of Deat	h (Check only one)	20110
nysicia nis cer I direct	examiner?  1 XYes 2 No Hospital: 1 Inpatient	t 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 X Other (Specia	(y) SCEN
ding Ph h. After th funeral	27. Manner of Death  1 Natural  5 Pending  28a. Date of Injury (Month, Day)	Year) Injury Work?	28d. Describe how injury occurred	
tal or Attending is after death.  al Diractor: After ed in by the funer ed in by the funer Certification	2X Accident investigation 3 Suicide 6 Could not be 28e Place of Injury	4:00 a M 1 Yes 2 No	Victim of house F: 28f. Location (Street and Number or Rura	
after d Diract Diract Lin by	4 Homicide determined building, etc.	y - At home, farm, street, factory, office (Specify)	319 E. Central Aver	nue
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi		my knowledge, death occurred at the time, date and place, examination and/or investigation, in my opinion, death occur	rederalsburg, Md. and due to the cause(s) and manner as s	stated.
Vithin Forth	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	Day, Year)
	30. Name and address of person who completed cause of dea	OCME	AUGUST 28,	
	Pamela E. Southall, mD	III Penn Street	t, Baltimore, Maryl	and 21201
State Registrar	31. Date filed (Month, Day, Year)  AUG 3 1 2004	's Signature & Sports		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item#2, perFh, G840, 2/24/05 TI

GOF	RY OGUN	BA	1 _ State	State of Maryland / Depa	artment of Health and Martificate of Death		0001 001
			Registrar  1. Decedent's Name (First, Middle, Last)	061	uncate of Death	Reg. 2. Date of Death	3. Time of Death
	Physici /Medi		Gregory		Ogunba	Month AUG。 1	Day Year 1520 P M
7	Examir		4a. Facility Name (If not institution, give si	,	4b. City, Town, or Location of Death		4c. County of Death
			PRINCE GEORGES HOS  5. Social Security Number 6. Sex	PTTAL CENTER  7. Age (In yrs. last birthday)	CHEVERLY  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	PRINCE GEORGES
Н	Funeral Director		220 /4 0220	M 2□F 33 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Iary 23, 19	9. Birthplace (State or Foreign Country) England
	D		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			
	Aaryla f sho	ō	Maryland Charles	Waldorf	cation .		10d. Inside City Limits 1 X Yes 2 ☐ No
	r 28a-	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	th with	a D	5401 Tilapia Court		20603	U	ISA
	tems ermi	ner	TI, Wallet Graces	Was Decedent Ever in U.S. 13. \     Armed Forces? 1	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 ☐ Yes 2/☐ No Specify:		Nigerian
21215-0036	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation 16a, Deced	lent's Usual Occupation	16b	American  . Kind of Business/Industry
21	ne. han " ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  AC	kind of work done during most of work DO NOT use retired)  Technician	Li	ncoln Tech
d 2	filed within 72 hours after death with the Maryland Hyglene. 4thar than "natural", or tlems 23a or 28a-1 show sht, the Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)	AC		(First, Middle, Maid	
an	lid be fental rked o lic eve	To Be	Dr. Victor Ogunba	ı	Margare		
Maryland	2 should and Men is marke	-	19a. Informant's Name/Relationship (Typ		g Address (Street and Number or Run		
	l and lealth im 27 har tr		Nomathemba Ogunba/W	711e 5401 '	Filapia Court Wald		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itam 27 is marked othar than "natural", or items 23a or 28a-1 show any injury or othar traumatic event, the Madical Establish must be notified at ADGE.		XXBurial 2 ☐ Cremation 3 ☐ Re	moval from State cemetery, cren	em. Gardens 8/25/		. Location - City or Town, State .dorf, Maryland
altir	permit. P Departme Importan any injur:		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		. Name and Address of Facility		
ä	Departing Departing Important in any ir gange.		Dodessa Offe	1 MO1323 Ada	ams Funeral Home F	.A. Aquas	co, Maryland
П				ations that caused the death. Do not enter cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Multiple	is juries		Onset and Death
	Examiner			Due to (or as a consequence of):	V		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):			
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	aiE		Due to (or as a consequence or).			
687	ifficate g phys as the	ledicai	d.		•••		
Вох	leath certific attending p	an/M	230. Was decedent pregnant	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery
.O. E	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)		Month Day Year
4	that the de led by the a detached f		Part II. Other significant conditions cont	ributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobaco	use contribute to the cause of death?
Records,	quires in signi	ed by				1 ☐ Yes	2 No 3 Probably 4 Unknown
ooa	e law requin has been si je 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä		Com				performed	? death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spitalszz	26. Place of Death		
of	ding Phys h. After this funeral di	n: To	XXYes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time of	00-1	201 0 0 1 1	6 ☐Other (Specify)
ion	Attending r death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury PUT-104 22:05	M 1 □ Yes 2 No	by amet	of a Car struck der veluiele
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate) South bound Brinch
	spital ours a leral [		29a. Certifier 1☐ Certifying Physi	Sfre cian: To the best of my knowledge, death			of Surra hs Rol. Clinton, MD
	To the Hospital or Attending I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Medical	(Check only Medical Examinone)	er: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	A 2	29c. License number O.C.M.E		Date signed (Month, Day, Year)
			Zahrulle				AUG. 20, 2004
M	0 11		30. Name and address of person who con ZTB/WLLAH	A-L/ 111 Per	n Street, Baltimo	re. Marvla	and 21201
111	Sta	ite	31. Date filed (Month, Pay, Year) AUG 2 4 2	32. Redistrar's Signature	1 4	_,	The state and the state of
	Regist	ar	HUG & 4 Z	John St.			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Ann Pack August 18, 2004 11:00 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min, (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Days 198-32-8532 Director 64 March 6, 1940 Pennsylvania Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28e-f show treumatic event, tra Medical Exeminer must be notified at Maryland 1⊠Yes 2 No Frederick Directo Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Alessandra Court, Apt. 201 21702 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 72 (Specify only highest grade completed) filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrator Delivery Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked off Be Robert Ahrens Ann Helena Voss ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Joannides / Daughter 1027 Chinaberry Drive; Frederick, MD 21703 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 21, 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A 21. Signature of Francisco Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Enterthe disease, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List simple on each line. Approximate Interval Between Onset and Death Physician Squamous Cell Carcinoma of Oral Cavity 5 years disease or condition resulting in death) a. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entay linear in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2X No Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital: 2 1 ☐ Yes 2xxNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death. Funerel Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0035152 8/19/2004 NO 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) I0J. Lee Krantz, M.D. 180 Thomas Johnson Drive, Ste. 101 Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrag's Signature State Sparks AUG 23

DHMH 17 Rev 1/2001

Registrar

2004

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan	d / Department of Certificate or			ene	20171
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las	Price			2. Date of Death Month	Day Year	3. Time of Death  115-8 P M
	Examin	er	4a. Facility Name (If not institution, give	of Auga (You	ed Swa	or Location of Death		4c. County of Dea	th thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. S  220-36-0424  Usual Residence of Decedent	9x, 7. Age ( <i>in yrs</i> . 43	Yrs. Months Day		8. Date of Birth (Month, Day, )	(ear) C	mp.
	death with the Maryland ims 23a or 28e-f show	Director	10a. State 10b. County  MD 64 \$7 \vec{E}1		y, Town or Location WANTON				10d. Inside City Limits
	s 23a or 2	eral Dire	934 Thousan	D ACRES RO	10f. Zip Code	56/ f Hispanic Origin? (S		g. Citizen of What C	
920	72 hours after de 'netural', or Item dical Exeminen	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No 1 Yes, Give Year or Dates:	if Yes, specify Co	uban, Mexican, Puert	Rican, etc.)	Black, Whi	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23a or 28e-1 show or other treumatic event, it as Medical Examinating the notified at	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	Jucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	cupation ne during most of wor red)	king	6b. Kind of Business	Industry  M.G.C.
Maryland 2	uld be filed Aental Hygi rked other tic event, L	To Be Co	17. Father's Name (First, Middle, Last)  Charles I	PRICE		0	ne (First, Middle, Mi	aiden Sumame)	770 6.
-	i and 2 should Health and Men iem 27 is marke sther treumatic		19a. Informant's Name/Relationship (	PICE	19b. Mailing Address (Streen 1934) 1005	et and Number or Ru	Ed. SWAT	City or Town, State,	21561
Baltimore	Ly and Ba		20a. Method of Disposition  1	Removal from State	SETT COMEM. 6	MADEUS 8.	23040	KLAND,	Md.
Ba	permit. Depart Import any inj		23a. Part1. Enter the disease, or com shock, or heart failure. List only	refringer	3 JaNES	ress of Facility A	EDMON or respiratory arres	T, WV. 2	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	Cell Cavani	ome of L	-hhj		Interval Between Onset and Death
8760,		dicai Examiner	Sequentially list conditions, francy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cus to (or as a nonseq c. Due to (or as a conseq d.					
.O. Box 68	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation of the birth the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ıl death 3 □Ectopic pregnar			23d. Date of de Month	livery Day Year
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Division of Vital Records,	The law ate has b page 2 si	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
/ita	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Manaitali			th (Check only one	)	
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Ž.	ding Phy th. After thi funeral	lo Lo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury W	Vork? □ Yes 2 □ No	200. Describe nov	rinjury occurred	
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,	To the P within 24 To the F complete	Σ	29b. Signature and title of certifier	Il ins	$\mathcal{D}_{\mathcal{O}}$	onse number 0033464	29	d. Date signed (Mon	th, Day, Year)
10.	HIVA		30. Name and address of person with	completed cause of death (Iter	17 23a) (Type, Print)	-4. Eglon	W26	716	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature				

			1 - For State Registrer	State of Ma		epartmen Certificat			and M	R	eg. N62		284	7 5-
	Physici		Decedent's Name (First, Middle, Last, Harriet	)	Richard	lson				2. Date of Deat Month August		004 ^{ar}	6:30	of Deafh∗' OAM
	/Medid Examin		4a. Facility Name (If not institution, give			4b. City,		Location o			1	y of Death		
			874 Hoyes-Sang Rui  5. Social Security Number 6. Sec		(In yrs. last birt	thday) If Under	1 Year	Frien		11e  8. Date of Birth		rret		or Foreign
	Funeral Director		324 <b>–</b> 34 <b>–</b> 1653	M 25xF 6		Yrs. Months	Days	Hours	Min.	Jan 1,	1941	Pola	place (State ntry) <b>n</b> d	or roraigit
land	W II		Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town	or Location		·				1	Od. Inside (	City Limits
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with th	Sa or 20	Director	10e. Street and Number 944 Fish Hatchery	Road		10f. Zip	Code 2152	20		1	0g. Citizen of	What Cour	ntry?	
<b>5-0036</b> 72 hours after death with the Maryland	al Hygiene. other than *natural', or Itams 23a or 28a-f ahow vent, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼N If Yes, Give Year or Dates:		13. Was Decedif Yes, special		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No- Rican, etc.)		ce - Americ ick, White,		te
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VISION OF VITA Attending Physician:	death. ctor: After this y the funeral d	<b>!-</b>	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			Bc. Injury Work	at Nur	21	8d. Describe ho			Home	
UIVISION tal or Attending	within 24 hours after death To tha Funaral Diractor: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, far (Specify)	m, street, factory	, office		2	8f. Location (Str. City or Town,		er or Rura	Route Nurr	nber,
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To th	withir To th comp	Me	29b. Signature and title of certifier	(/ !			. License				d. Date signe		Day, Year)	
			Mayaret a	Kum	MA		024	0650			8/21/6			
	3		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (	Type, Print)	Hick	1 share -	/	Daktan	1 MX	215	うつう	
h	Sta	-	31. Days filed (Month, Day, Year)	32. Registra	1700	arry (	10	way		- Make alread	-1 0	3	<i>-</i>	
	Registr	di	AUG 2 3	LUUY	102 y	Anna M	D							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year aner ameis 1100 PM Louise 04 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner County MEmorial HOSpital GARRETT AKLANd GARRET (0. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 02030-8923 1 M 2 2 F Director MA 1/23/1939 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f show the Madical Experiment the notified at Yes 2□No Director MA. Middlesex Framingham 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Socian AUS 01701 U USA death v Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event, Ing 11 Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည James Kezer Gertrude Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Upper Joclyn Ave., Framingham, MA James H. Fainey/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug.20,2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Belle Vernon Cemetery Belle Vernon, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Newman Funeral Homes, P.A. Kemal P.O. Box 275; Grantsville, Maryland 21536 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearly failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of) Examiner Kel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed To the Funere! Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2.200 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1. inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) CL 42464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sotiere Savopoulos, MD 208 Maryland Highway, Suite 3, Mt. Lake Park, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 3 2004 Registrar

B.K.S BERRY ROGERS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AUG. **Physician** 2004 Berry 1350 P M В. Rogers 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Oct. 19, 1943 6. Sex **Funeral**  Birthplace (Stete or Foreign
Country) 1 X M 2 □ F 60 246-64-1167 Director North Carolina Usual Residence of Decedent death with the Maryland works 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ad other than "natural", or items 23a or 28a-f show avant, the Medical Eraniner must be notified at Director 1X Yes 2 No Maryland Prince George Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 67th Place 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married I Yes 2 No Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 € Divorced Specify: Year or Dates Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sanitation Worker P.G. County Government 27 is marked other traumatic avant, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental Hitam 27 is marked others. Be Unknown Alberator Rogers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of Itam 27 is or other tra Antionette Rogers/Daughter 3011 Warden Street, N.W., Washington, DC 20001 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Harmony Memorial Aug. 29,2004 Landover, Md. 22. Name and Address of Facility Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Ligensee 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, r respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike, Forestville, MD Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) PIK /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To tha Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown pluods 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an page 2 certificate 1 X Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient Certification: To 1 ☐Yes 2 ☐ No 3□ DOA the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. injury at Work? After 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 🗋 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) AUG. 3.9, 2004 29b. Signature and title of certifier 29c. License number O.C.M.E 30. Name and address of person who completed cause eath (Item 23a) (Type, Print) THEODONE MIKE. 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 6 2004

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug 31, 2004 6:45 am Roby Μ. James 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month. Day. Feb 7, 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign 5. Social Security Number Country) 1 M 2 □ F 213-16-9347 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Allegany Cumberland 1 ★es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 542 Winifred Road 21502 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates: \ 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced WWII 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Register of Wills Registrar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Clarence Roby Persis Shrout Roby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
542 Winifred Road Cumberland MD 19a. Informant's Name/Relationship (Type, Print) MD 21502 wife Audrey Roby 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Hillcrest Memorial Park 9/3/2004 Cumberland MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Nam}Scarpelli funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 Yes 2 No

/Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Box 68760. the tor use as signed by the a P.O. Division of Vital Records, 2 should page funeral director, this s after death.

I Director: Af
id in by the fur within 24 hours a To the Funeral I tilled

**Physician** 

/Medical

Examiner

**Funeral Director** 

Be Completed by

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
and: If item 27 is marked other then "naturel", or items 23a or 28a-f show and it item 27 is marked other then "naturel", or items 23a or 28a-f show and the real marker to the Madical Examinant to not life a may or other treatments event, the Madical Examinant constitution.

permit. Pages 1
Department of H
Important: If Ite
eny injury or ot

**Physician** 

Baltimore, Maryland 21215-0036

by Physician/Medical Be Completed Medical Certification; To

1 Yes 2 Ho 27. Manner of Death 1 Matural 2 Accident

(Check only one)

investigation 3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D54411 29d. Date signed (Month, Dey, Year)

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Beverly Calkins M.D.

500 Memorial Ave Ste 105 Cumberland MD 21502

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

10a. State

MD.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

a-f show

For State Registra

Social Security Number

215-14-0278

Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

ST. MARYS HOSPITAL

10b. County

CARROLL

LOUIS HENRY SCHLEUPNER

7. Age (In yrs. last birthday)

10c. City, Town or Location

WESTMINSTER

84

4b. City, Town, or Location of Death

tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day, Year)

LEONARDTOWN

2. Date of Death

MAY 15,1920

Dav

21

ST.

Month

August

3. Time of Death

96:31A M

Birthplece (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 XNo

2004

MARYS

MARYLAND

4c. County of Death

	128 th	ě	10e. Street and Number			104	Zin Code		T I	10a Ci	izon of Mhat C	ountou?
	death with the	Dire		IOD DD		101.	Zip Code	E O		-	tizen of What Co SA	bunity?
	ath 8 23	ra	1538 HUGHES SE				211					
36	s 1 and 2 should be filed within 72 hours after death with the file Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28, other traumatic event, the Mudical Examinating that be not	by Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW			ecedent of H specify Cub s 2\tilde No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Tut	
8	urai'		3 Widowed 4 □ Divorced		II			·			**	
5	n 72	lete	15. Decedent's Edu (Specify only highest grad		(	Decedent's U Give kind of life. DO NO	work done	during most of working	ng	16b. K	ind of Business	/Industry
212	ed within rgiene. er than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				GUARD		SE	CURITY	
land	ould be filed Mental Hygi varked other vatic event, 1	To Be	17. Father's Name (First, Middle, Last) WILL	IAM HENRY S	CHL	EUPNE	ER	18. Mother's Name ANNA KA				ARNOLD
ary	2 sho		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. i	Mailing Addr	ess (Street	and Number or Rura	l Route Numbe	r, City o	or Town, State,	Zip Code)
Σ	1 and 2 Health a tem 27 is		MARY E. SCHMIDT	- NIECE	153	88 HU	GHES	SHOP RD	.,WEST	MIN	ISTER,	MD. 21158
Baltimore, Maryland 21215-0036	000		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery.	Disposition (in crematory of JNTY	or other plai	CB) ATION 8/	ate 23/04		cation - City or	
alti	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service License	99 // /		22. Name	and Addre	ss of FacilityFLE'	rcher -	FUN	ERAL F	HOME
ä	Depa Impo any ir		1 Juny / fre	blu le				AIN ST.,				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the deat ne cause on each line.	th. Do no							Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	Bilater	el p	nermer	ma	& hypo	dia			onot and boath
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of	):		1	1 /	. 1		
٧.	Lyammei		Sequentially list conditions,	, Ivon sn	rall	Cel	l Cé	aranoma	of L	in		
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of	):						
	acute ind trans	аш	that initiated events resulting in death) Last	Atrial	Feb	Mat.	192.					
Ö,	e ext ian a urial-		resulting in death / Last	Due to (or as a conseq	1							
376	ate b hysic he b	Ilca		1 Dely	ra s	100	+					
39	ng pl	Med	IF FEMALE:									
PNER of Vital Records, P.O. Box 68760,	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3c. tf yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death	3 □Ectopic 5 □ Other		/			23d. Date of del Month	ivery Day Year
ď.	that t	P	Part II. Other significant conditions cor	ntributing to death but not res	ultina in t	he underlyin	o cause oiv	en in Part I.	23e. Did to	bacco :	se contribute to	the cause of death?
rds,	w requires t been signe should be	6	•									obably 4 Unknown
Reco	Physician: The law raths certificate has be all director, page 2 sh	Completed							24a. Was a autop: perfor	sy med?_	death?	itopsy findings available completion of cause of
E E	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of Death			1	
UPNER of Vit	Physician: this certifica al director, p	10	examiner? 1 \( \text{Yes}  2 \( \text{PNo} \)	lospital: 1 Inpatient 2	ER/Outp	atient 3	DOA Oth	er: 4 Nursing Hom	e 5 ☐ Resid	ence (	5 □Other (Spe	cifv)
$\supset$	ding Ph h. After th funeral	Ë	27. Manner of Death  1  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Tin tnji		28c. Injur Wor	y at 2	8d. Describe h			
SCHLE Division	or Attanding after death. Diractor: Afte in by the fune	Certificatio	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farn y)	n, street, fac	-		8f. Location (S City or Tow	treet an n, State	d Number or Ru )	ural Route Number,
TONIS	To the Hospital or Attanding Physwithin 24 hours after death.  To the Funeral Diractor: After this completely filled in by the funeral director.	Medical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sicien: To the best of my kno ner: On the basis of examina	owledge, oution and/	death occurr or investigati	ed at the tin	ne, date and place, a pinion, death occurre	nd due to the c	ause(s)	and manner as place, and due	stated. to the cause(s)
$\vdash$	the thin 2 the mple	Mec	29b. Signature and title of pertifier	and manner stated.	_		29c. Licens	e number		od De	e signed (Montl	h Clay Vans
	T V O		255. Signature and title of retiner	12.61	2		100			.su. Dat	1 . 1	
	WS WA	1	July 10/0	Will full	1.		00	3060473		8	121/2	004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 4 2004

MEHRDAD AKHLAGHI M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

we & Goods **ORIGINAL** 

ST.MARYS HOSPITAL

32. Registrar's Signature

P.O.BOX527 LEONARDTOWN, MD. 20650

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar				ertificate of		III WEIII	, ,	9. No ? 11 11	1. 201.01	
Physici /Medio		Decedent's Name (First, Middle,	_	Α.	STE	MLE		M	ate of Death Ionth	Day Ye 18, 20		
Examir		4a. Facility Name (If not institution,	give street and number)			4b. City, Town,	or Location of	Death		4c. County of D		
Funeral			6. Sex 7. Ag		last birthday	Berl:	r If Under 2		ate of Birth	Worce	ster Birthplace (State or Forei Country)	
Director		058-28-9093 Usual Residence of Decedent	1MM 2□F	67	Yrs.	Worth's Days	i iouis		22-37	7	NY	
show	7	10a. State 10b. County Md. Worce	ator		y, Town or L ean I						10d. Inside City Limi	
ith the Marylar or 28a-f show	Director	10e. Street and Number	2061	00	ean i	10f. Zip Code			100	g. Citizen of What	1 Yes 2 N	
23e of	ai Di	338 Ocean Par	kway			2181	11			USA	, , , , , , , , , , , , , , , , , , , ,	
filed within 72 hours after death with the Maryland Hygiene. Hysiene. Ithe Madical Examiner must be notified a	by Funerai	11. Marital Status  1 □ Never Married 20€ Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 12 Yes 2 1 1 Yes, Give Year or Dates:	No		Was Decedent of If Yes, specify Cu		n? (Specify Y Puerto Rican	'es or No- , etc.)	Black, V	American Indian, Vhite, etc.	
"natural", dical Exe		15. Decedent's (Specify only highest	Education	30-3	16a Dece	edent's Usual Occu e kind of work done DO NOT use retir	upation e during most d	of working	16	6b. Kind of Busine	White ess/Industry	
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B la b ♥	To Be	17. Father's Name (First, Middle, La Walter Stemmle						s Name (Firsi nor O		uiden Surname)		
d 2 should be th and Mental 7 is marked of traumatic ev	-	19a. Informant's Name/Relationshi			19b. Mail	ing Address (Stree					e, Zip Code)	
		Ann M. Stemmle	e Spous		338	Ocean F	Pkwy.,					
Pages ment of ant: If it		1 Paurial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State			osition (Name of matory or other place) On Nat.		8-2		c.Location-City		
permit. Departr Imports any inj		21. Signature of Funeral Service Li	canage		2	2. Name and Addr	ess of Facility			an take-salar	55-005-501	
Physician		23a. Palti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septimental Septiment										
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requires that the death certi een signed by the attending nould be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[	□Ectopic pregnanc □ Other (specify) _	>y			23d. Date of Month	delivery Day Year	
v requires the been signed should be de	by	Part II. Other significant condition:	s contributing to death be	ut not resu	ılting in the u	inderlying cause gr	ven in Part I.	23			to the cause of death?  Probably 4 12 Unknow	
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Phyaician: this certific al director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 M	R/Outpatier	nt 3 DOA Ot		Death (Chec		- Flori - 12		
ding h. After fune		27. Many of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	-	28b. Time o Injury	f 28c. Inju		28d. De		e 6 Other (Sinjury occurred	oecify)	
or At ter d irect	Certification;	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	t be 290 Place of Inju	ury - At ho c. (Specify	me, farm, sti	reet, factory, office	143 2 140	28f. Lo	cation (Stree by or Town, S	et and Number or State)	Rural Route Number,	
To the Hospital of within 24 hours at To the Funeral D cumpletely filled in	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examinat	vledge, deat ion and/or in	h occurred at the ti vestigation, in my o	ime, date and popinion, death	place, and dur occurred at th	e to the caus ne time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)	
To th within To th c.mp	Me	29b. Signature and title of certifier	D			29c. Licen:	se number		t t	Date signed (Mo		
	-	20 11	a completed source of de									
Earl	1	30. Name and address of person wh	o completed cause of de	7 29	23a) (Type,	Print)	100	1.	18 . 18	21011		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** IRENE HOUSE SIGLER August 19, 2004 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Frederick Memorial Hospital Frederick 8. Date of Birth Oct. Page 199. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 21 F Months 214-78-0273 74 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County r then "naturel", or Items 23a or 28e-f show the Madical Example must be notified at 10c. City, Town or Location 10d. Inside City Limits MD Frederick Director Middletown 1 ☐ Yes 2 ☐xNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7709 Picnic Woods Rd. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other treumatic event, The Madie 2005.  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee A. House Velma Guyton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sigler (Husband) 7709 Picnic Woods Rd., Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lutheran cemetery 8/23/04 Jefferson, MD ` 4 □ Donation | 5 □ Other (Specify) ute of Finer Service Li Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 eft). Ever the disease, or conshock, or heart failure. List only pligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia disease or condition resulting in death) Ihr /Medical Due to (or as a consequence of) **Examiner** enoselenotie Cardiovascular if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 XNatural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a ro the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) levenge ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , mo 310 W. 94h Sts Frederick MD 21701 evangre 32. Registrar's Signature 31. Date filed (Month, Day, AUG State Registrar

04-5507 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. EDWARD B. SMITH State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item #23a&27 per me G835-9#17716 the atth 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 ear 26 Day **Physician** AUG. Edward Brown Smith 0120 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | ff Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F 27 217-27-0493 Vre Director Aug. 13. 1977 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. Count 10d. Inside City Limits show d other than "natural", or Items 23a or 28a-f show event, the Medical Exactive must be notified at 1 ☐ Yes 2 ☑ No Director Glen Burnie Anne Arundel Co. MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21061 U.S.A. 5 Roosevelt Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status within 72 hours after 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) Service Technician Telephone Company 12 filed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1s marked othe any injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Saundra M. Thompson David L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Abington Manor Drive, Huntingtown, MD 20639 Saundra M. Romijn (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. Dars, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 2004 Clinton, Maryland Lee Crematory 21. Signature of Fu 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 Mease M. Alee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Disseminated Sarcoidosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed and physician ar s the burial-t Due to (or as a consequence of): P.O. Box 68760 use as attending

Physician/Medical ģ Completed Be 2

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within 24 hours after death To the Funeral Director:

page certificate

Division of Vital Records,

or Attending Physician:

the Hospital

9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 27. Manner of Death Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

5 Pending

investigation

6 Could not be determined

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of defivery Month Day Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☑Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No

26. Place of Death (Check only one)

AUG.

26, 2004

Other: 2X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

Califulati 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 ABIUCE AH

State Registrar 31. Date filed (Month, Day, Year)

32. Registra Signature 0 1 2004

Hospital: 1 | Inpatient

28a. Date of Injury (Month, Day Year)



28b. Time of

fnjury

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 23, Cleon R. August 2004 4:00 P Stull, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Frederick
If Under 1 Year | If Under Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, July 7, 19 **Funeral**  Birthplace (State or Foreign Country) 1 GM 2 □ F Months Days Hours 213-16-0164 93 Director July | 1911 Maryland Usual Residence of Decedent death with the Maryland 7 Is marked othar than "natural", or Items 23a or 28a-f show traumatic avant, the Modical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6143 Longbranch Road 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours atter arment of Health and Mental tygiene. ortant: If itam 27 Is marked other than "natural; or Ite Inlury or othar traumatic avant, Ite Mcdical Ext. mina 1 ☐ Never Married 2 A Married 1 ZYes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: white 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Masonary contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Resley V. Stull Mattie Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleon Stull, Jr. - Son 6139 Longbranch Road, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Rocky Springs Cemetery 8/27/2004 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Duce. 1621 Opossumtown Pike, Frederick, Maryland Me ate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. facter Immediate Cause (Final Physician naeste disease or condition resulting in death) year /Medical Due to (or as a confequence of): Examiner Sequentially list conditions Directo (or as a nonsecuence of) cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Ho 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an has autopsy performed The this certificate 2 2 No 1 ☐ Yes To the Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 1 🗌 Inpatient 4 Landring Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 25 2004 Registrar

			1 - For State Registrar	State of	Marylar		artmen rtificate				lental H	ygiene	nnl	}	2848	l,
	Physici	an	Decedent's Name (First, Middle,								2. Date of D	eath Da	v Y	ar	3. Time of De	əath
	/Medi	cal	Elizabeth Irvin								August				7:00	РМ
	Examir	ner	4a. Facility Name (If not institution,	give street and numb	oer)				Location of	of Death			. County of I			
-			Casey House  5. Social Security Number 6	. Sex 7.	Age (In yrs.	last high days	Rock If Under		.e If Under	24 Hrs	0.0		ntgom			
н	Funeral Director		215-58-9833	1 ☐ M 2 🔀 F	5 Age (III yis.		Months	Days	Hours	Min.	8. Date of B (Month, D Feb 26	irth Ja <i>y, Year)</i> 5 107	9.	Birthpl Coun	ace (State or F Ty) Cornia	oreign
			Usual Residence of Decedent			J					reb Z	194	9 6	311)	ornia	
	ylanc		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City L	Limits
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumetic evant, the Medical Examinar clust be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give Year or Date	es? Mo	1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:		ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V	America Vhite, e	tc.	
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ם	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle	e, Maiden	Sumame)			
<u>X</u>	Ment Ment arked etic	2	Irvin Lechliter						Eliza	abeth	n Cille	y				
, Mar	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship Susan L. Eyclesh			19b. Mailin 18410	g Address Geor	(Street a	^{nd Numbe} Avenu	or or Rura 1e 01	ney, M	per, City o [ary1	r Town, State and 20	e, <i>Zip</i> (	Code)	
Baltimore, Maryland 21215-0036	Pages 1 nent of He int: if itan		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Cont		ate C	lace of Disposementery, crem Arunde	natory or ot	her place		ugu 200	25, 14		nton,			
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ĺ.	Physician but state pe executed but state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state private state state private state private state state private state state private state state private state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state state st	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Lead Stage Liver Disease of the conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):						, such as	cardiac o	r respiratory a	arrest,			Approximate nterval Betwee Onset and Dea	en
. Box 6	death certif e attending od for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥No 9 □ Unknown		1 2 ∏ Fetal tat time of de	death 3 🗌	Ectopic pre Other (spe					2	23d. Date of Month		, ay Year	
S,	requires that the	by P	Part II. Other significant conditions	contributing to deat	h but not resu	alting in the un	derlying ca	use givei	n in Part I.		23e. Did t	obacco us	se contribute	to the	cause of death	1?
coras,	equir sen s	ted									10	Yes 25	₹No 3□	Probal	oly 4 🗌 Unkn	iown
Lec	The larate has	Completed									24a. Was auto perfo 1 \( \text{Yes} \)	osy ormed?	24b. Were prior death 1 🗆 Y	o comi	y findings avail pletion of cause	lable e of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o					
io uoi	ng ffei	atlon: To	1 Yes X No  27. Manner of Death 1 Xatural 5 Pending 2 Accident investigati	28a. Date of li		ER/Outpatient 28b. Time of Injury		C. Injury	`4□Nur at es 2□N	2	ne 5 Resi	dence 6 how injury	Other (S	oecity)	hospice	ż
DIVISION	tal or Attending F 's after death. al Director: After ed in by the funer:	Certificat	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of	Injury - At hore etc. (Specify)	me, farm, stre	et, factory,	office	===	2	8f. Location ( City or To	Street and vn, State)	l Number or	Rural I	Route Number,	
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical	29a. Certifier 1 Certifying F (Check only one)	Physician: To the be eminer: On the basis and manner	or examinati	wledge, death ion and/or inve	occurred at estigation, i	t the time	, date and nion, death	place, a n occurre	nd due to the d at the time,	cause(s) a date and	and manner place, and d	as stat ue to ti	ed. ne cause(s)	
1	with To t	≥	29b. Signature and title of certifier	- 1	. ^	110	29c.	License	number			29d. Date	signed (Mo	nth, Da	y, Year)	
(1	419	-	-140	Kr -				35635	5			Augus	st 24,	20	)4	
(1	1		30. Name and address of person who					_	9	-						
	-Ct-		Joseph Kaplan M.I 31. Date filed (Month, Day, Year)		lincast <b>f</b> rar's Signati	er Mil	⊥ Rd.	Roc	ckvil.	le,	Maryla	nd 20	855			
	Stat Registra			2004	_		boarte	,								

# VOID

# CERTIFICATE #

2004-28485

# SEE

**CERTIFICATE #** 

2004-28755

State of Maryland / Department of Health and Mental Hygiene For Stete Registrer AMEND ITEM #23a-c PER PHY C895 if GOPON POLY SAITH 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 20 2004 Year **Physician** 1740 P Richard Seidman /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F 047 12 6461 85 Yrs. Director Aug 31 1918 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "naturel", or Items 23a or 28a-f shov The Medical Examiner must be notified at Solomons Calvert Maryland 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20688 11750 Asbury Circle # 104 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white ģ 3√ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) special machinery engineer Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other toury or other treumatic event, In 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown Rose Harry Seidman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13207 Deerfield Ct. Lake Oswego OR 97835 William Seidman- son 20b. Place of Disposition (Name of 1992) 2004 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. Metropolitan Funeral Service * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac errespiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia ASPIRATION PNUEMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration CHRONIC ASPIRATION -TERMINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit CVA - DYSPHAGIA Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2√10 Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🗙 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Callerin June 22,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Rd, Suite 310 Prime Freden MO GWYNEYU 32. Registra s Signature

Registrar

			1- State of Maryland Der 1- State of Maryland Der 1- Registrar 4a	8/04dhb ertificate of Death		3. No? 1) 1	281.87
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yea	3. Time of Death
	/Medi		John Ernest Shockey  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	4 2004	5:55AM ^M
	Exami	ner	Broadmore Assisted Living	Hagerstown		4c. County of De Washing	ton County
	, Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	9.8	irthplace (State or Foreign
	Director		214-09-0922 XM 2 F 97 Yrs.	Months Days Hours Min.	(Month, Day, ) Apr. 13		aryland
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	r 28a-f show	to	Maryland Washington Hagersto	งพา			1 XYes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What (	Country?
	death with the Maryland ms 23e or 28a-1 show Imust be notified at		919 Dewey Ave	21742		U.S.A.	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
30	a o E	by Fi	1 □ Never Married 2 □ Married 1 □ M es 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:	,,	Specify: Wh	
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7	filed will Hygien ther th	Con	12	wner		Piano &	Organ Co.
Maryland	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Ž	hould d Mer narke natic	은	Jacob E. Shockey  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Nellie	C. Kopp	isch	
20	th and treur	1 8	Lindley Shockey Phodes / Daughter 9061	ng Address (Street and Number or Rura	al Route Number, C	City or Town, State,	Zip Code) 32082
ē,	thealth tem 27 other tr		Lindley Shockey Rhodes/Daughter 8961  20a. Method of Disposition 20b. Place of Disp	osition (Name of		Vector - City o	
saltimore,	Pages ent of nt; If i			matory or other place) en Cemetery Aug.		,	Maryland
<u> </u>	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than eny injury or other freumatic event, III M. QDGs.			2. Name and Address of Facility Dou		_	-
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or head failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest	,	Approximate Interval Between
	Pnysician	0 1	Immediate Cause (Final disease or condition	PNEW MON. A			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or is a consequence of):	1			10
		70	Sequentially list conditions, b. A CMA A Due to for as a consequence of:	51A			Months
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	death certifi attending p	lan/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of de	•
5	the a	Physiclan/Me	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month	Day Year
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	P.	Part II. Other signifficant conditions contributing to death but not resulting in the t	nderlying cause given in Part I	23e Did tobac	CO USE COntribute t	o the cause of death?
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200001	w requir been si should	lete	Africal Chaldball		24a. Was an	/ \	
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	ysicien: The is certificate hadrector, page	a	25. Was case referred to medical	26. Place of Death	(Check only a a)	No 1 □ Yes	s 2□No
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			27. Manner of Death  Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		8d. Describe how i		Living
	Attending ir death. ector: After by the fune	catl	2 Accident investigation	M 1 Yes 2 No			
	P di c	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	l8f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
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	15		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		107	, 2001
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	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
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2			17. Father's Name (First, Middle, Last	)	Dice	er ran h		me (First, Middle,		Care
an	ed la bo	) Be	Frank Sherid	an			Salli	e Litti	leton	
Maryland	should Ind Men	은	19a, Informant's Name/Relationship		19b. Mailir	ng Address (Street a			r, City or Town, State,	Zip Code)
Ma	d 2 sho th and t7 is my traumy		John S. Timmon						MD 21804	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition							
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			enock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
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Box	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
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σ	that hed b		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
Records,	uires sign	d by	HM.					1 🗆 Y	es 2□No 3□P	robably 4 Albridanown
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Division	i Diffic	Certification:	4 Homicide	building, etc. (Specif				City or Town	n, State)	
	Hospital or 24 hours afte Funeral Dir tely filled in I			hysician: To the best of my kno	wledge, death	occurred at the tim	ne, date and place	e, and due to the c	ause(s) and manner a	s stated.
	Ho Fui letely	Medicai		miner: On the basis of examina and manner stated.						
	To the Hospital within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier	11		29c, License	number 4	/ 2	29d. Date signed (Mon	th, Dey, Year)
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			30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре,	Print)			1	
l			Igraha	L. D. Na		ms.				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature 4	loca v	11			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 6:40 PM AUGUST TRUITT 18 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO WICOMICO NURSING HOME SALISBURY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days Hours 213-22-8382 78 Director FEB. 7, 1926 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or itams 23a or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD WICOMICO PARSONSBURG 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 31425 ZION ROAD 21849 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC TRUCKING COMPANY Pages 1 end 2 should be filed w thent of Health and Mental Hygien tant: If Item 27 is marked other to jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HARRY TRUITT BESSIE LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DORIS JEAN TRUITT- WIFE 31425 ZION ROAD PARSONSBURG, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. * 4 ☐Donation 5 ☐ Other (Specify) LEWIS CEMETERY 8/23/2004 WILLARDS, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Facility BOUNDS FUNERAL HOME 705 E MAIN STREET SALISBURY, MD 21804 23a. Parl 1. Enter the disease, or completations that caused the death shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediete Cause (Final disease or condition resulting in death) Physician YPOXEMIA /Medical Due to (or as a consequence of): Examiner NEUMANA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initieted events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month detached for Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2X No certificate 2 No 1 Yes 1 Yes (OFOWARY 25. Was case relerred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral I Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 0060515 Jahreles 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) 614 EASTERNSHORE DR., SALISBURY, MD 21804 MAHESHA THIMMARAYAPPA, M.D. 31. Date liled (Month Pay, Year) AUG 23 2004 32. Registrar's Signature State sporks Registrar

DHMH 17 Rev 1/2001

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	/Medi		Myron J. Turn	er							August	Day 22	Year 2004	4:52	A M
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7			Usual Residence of Decedent					19		l	Aug 3,	2004	MI	)	
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	8a-f s	Director	MD Wicom	ico		Salisbu	<b>-</b> Y							1 ☐ Ye	s 2 No
	with th	Dire	10e. Street and Number	Count			1 '	Code					n of What Coul	ntry?	
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and	d be i	o Be	Leroy Turner,	,							e (First, Middle,		umame)		
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	s 1 and 2 should be filed within 72 hours after death with the Maryiar if Health and Mental Hygiene. itam 27 is marked othar than "natural", or items 23a or 28a-f show othar traumatic event, in a Medical Exercites must be notified at		Leroy Turner,	Jr./fathe	er						lisbury			Code)	
J.	ges 1 and t of Health It itam 27 or othar tr		20a. Method of Disposition			20b. Place of Dis					Date	_	tion - City or To	wn, State	
<u><u>Ë</u></u>	Pages nent of H ant: It its ury or of		1 ☑ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (5		State	Springhi				8/27	/2004	Sali	sbury,	MD	
Baltimore,	permit. Pages 1 Department of H Important: It its any injury or ot		21. Signature of Funeral Service	Licen e			22. Name ar	d Addres	s of Facilit	ly					
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	/Medical Examiner	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to immediate cause. Einer Underlying Cause (Disease or injury that initiated events	aprobab Due to (c	le s	eu Illera	vascu1	ar c	coagu	lati	on compi	Licati	ing	Approxima Interval Be Onset and	tween
Box 68760,	Attending Physician: The law requires that the death certificate be executed rindeath.  If death.  Actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	come of	Fetal death 3	□Ectopic pr	egnancy				23d	. Date of delive	-	Many
P.O.	that the death ed by the atte detached for	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	wn		Other (sp								Year
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			30. Name and address of person				,								
			Jasha ZGV				-			Ba	ltimore	Mary	yland 2	1201	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2004	yistrar's	Signature	Spi	rels		-					

Maryland 21215-0036 Hygiene. and Mental Hygie should be f Health Item 27 Baltimore, ō <u>=</u> ö

Tinsman, Chester

the attending physician and hed for use as the burial-transit certificate be executed P.O. Box 68760, Division of Vital Records, peen this After

CHIH

Amend Item #8 per th 6835 Penartment of Health and Mental Hygiene
Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month CHESTER LEVERING TINSMAN /Medical 23, 2004 10:45P August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Dete of Birth 10/23/1929 Athpla Berlin Nursing and Rehabilitation Center Berlin Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. hplace (State or Foreign Months Days Hours 1 XM 2 ☐ F Director 74 Washington, DC 579-32-8576 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2000 MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9230 Mary RD 21811 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Purchasing Agent Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Unknown) Tinsman ပ Beatrice Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Helen Tinsman</u> 9230 Mary RD Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 8/24/04 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or QQCE. ³ 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crematory Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of uner Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final zheimer Physician disease or condition resulting in death) ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy perform 22 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: y ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Yes 2 No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1st Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year) 24/04 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1269 , and NICholos Bordella 31. Date filed (Month, Day, Year) 32. Polistrar's Signature State AUG 2 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Day Year **Physician** 1839 THOMPSON **JOSHUA** MILES 2 04 /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Fallity Name (If not institution, give street and number) **Examiner** Wichnes eningula Kegional Medical Center If Under 24 Hrs. If Under 1 Year Months Days Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 10/27/1922 1 ☐ M 2 🔀 F Months Hours 81 Yrs. Maryland Director 213-12-5157 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow retinual be notified at 1⊠Yes 2 No Director MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 USA 1508 Linden Drive Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married other traumatic avant, the Medical Evant ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced WWII white 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Civil Service 12 should be filed w h and Mental Hygier 7 Is marked other th 8 Firefighter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mable Richardson ပ Joshua Miles Thompson 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 W. Central Ave., Federalsburg, MD 21632 Linda T. Turner (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pitts Creek Presbyterian Cemetery ₹ <u>=</u> tX Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department (Important; If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Pocomoke City, MD P.A. Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 21 Signature of Funeral Service Licensee Machael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CVO /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury Examine The taw requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ cate has been signage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Vital 2 No 1 Yes Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ♣ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No jo this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After Division Hospital or Attending 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0057410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CH. 12+1 Peninsula Regional Med. Center SHisbury, Md. En Summa 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 4 2004 Registrar

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	Physic	ian	Decedent's Name (First, Middle, Last)							ath	Vest	3. Time of Death		
	/Medi		Jean Dye Thompson						Month August	Day 21	Year 2004	3:30 A ^M		
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		ш	530 Wintersweet Court  5. Social Security Number 6. Sex 7. Ag	a da ca la distrib	lá l Indos		napol			Į.	ne Aru			
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	or 28	Director	10e. Street and Number		10f. Zip (	Code				10g. Citizen o	f What Coun	ntry?		
	ath w	ra	530 Wintersweet Court				21401			U.	S.A.			
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Maryland	l and 2 s tealth ar im 27 ls im rreu	1 8	19a. Informant's Name/Relationship (Type, Print) Page Anderson/daughter						l Route Number			Code)		
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Baltimore,	permit. Pages of Department of Himportent: If ite any injury or ot once.	١,	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo- cemetery, cren										
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Вох	death certifii e attending p	Physician/Me	23b. Was decedent pregnant in the past 12 gronths?	2 ☐ Fetal death 3 ☐	Ectopic preg						ate of deliver	y Day Year		
		ysic	1 ☐ Yes 2 ☑ Nes 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death 5 □	Other (spec	cify)					G1(1) E	Say Feat		
	that the ned by th detache	y Ph	Part II. Other significant conditions contributing to death but	t not resulting in the un	derlying cau	ise giver	n in Part I.		23e. Did tob	acco use con	tribute to the	cause of death?		
Records	as been sign	d by							125 Ye			bly 4 🗀 Unknown		
00	s peen s	Completed							24a. Was ar	24h	Were autons	sy findings available		
œ	The lav	E o							autops: perform	ned?	prior to com death?	pletion of cause of		
	ysician; The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26. Place of	of Death	1 ☐ Yes 2 (Check only one		1 ☐ Yes 2	R□ No		
o o	Physician; this certific al director,	10	1 Yes 2 No Hospital: 1 Inpatier	t 2 ER/Outpatient	3□ DOA	Other			2 4	nce 6 🗆 Oth	ner (Specify)			
	ding Ph	ou:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injun (Month, Day	Year) 28b. Time of Injury	280	. Injury a Work?	at	21	8d. Describe ho					
120	Attending r death. ector; After by the fune	icati	2 Accident investigation		М		es 2 N							
Division	after a	Certification:	4 Homicide determined 28e. Place of Inju building, etc.	ry - At home, farm, stre (Specify)	et, factory, c	office		28	Bf. Location (Str City or Town	eet and Numb , State)	er or Rural I	Route Number,		
_	Hospitel or Attenç 24 hours after death 5 Funerel Director; etely filled in by the		29a. Certifier Certifying Physician: To the best of	my knowledge death	Occurred at	the time	data and	place c	ad due to the	una(s) = - 1				
	lo the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edicai	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or inve	estigation, in	my opir	nion, death	occurre	d at the time, da	te and place,	anner as stat and due to th	he cause(s)		
	vithin 2 To the complet	_	29b. Signature and title of certifier		29c. L	icense i	number		29	d. Date signe	d (Month, Da	ay, Year)		
7			1 / of T Veltine V	uh	I	24	804			8/23	164			
			30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P		6-	,	1		1110	2111-	,		
	Stat	e	31. Date filed (Month, Day, Year) 32. Refistrar		1	1100		/ j.u	negely	TV()	2190	/		
	Registra	ar	AUG 2 4 2004	w st A	DOW.	3								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0.50 AN nomas 2004 /Medical 4c County of Death ia. Facility Name (If not institution give street and number)
MI) Ichium Ott Forest VIIIe Health & Retab
7490 Marlboro Pike 4b. City, Town, or Location of Death Examiner nce Georas If Under 24 Hrs. Date of Birth (Month, Day, Year) 6/6/12 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Security Number **Funeral** Days 578-28-1296 1 X M 2 □ F 92 Director Laurel Md. Usual Residence of Decedent Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or itams 23s or 28a-1 ahow other traumatic event, the Medical Eventret must be notified at 1 Yes 2 No Md. P.G. Capitol Heights Director the 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 6510 Weston Avenue 20743 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after cand Mental Hygiene.
Is marked other than "natural", or Itar 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify 3 Widowed 4XDDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Lumper 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown ျှ A opt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sinent of Health and and 11 item 27 is n Montressa D. Terry-Lewis/Daughter 1506 Brooke Rd. Capitol Hgts., Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 0 Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 8/26/04 Feltsville, Md. 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
H.S.Washington & Sons Co., Inc. W. 4925 Burroughs Ave., N.E., Wash., D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiorespiratory Failure /Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transil that the death certificate be executed Hypertension Due to (or as a consequence of) Box 68760. Pressure Ulcer IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 2 1 No Sale 1 ☐ Yes Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 51520 8-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Pishdad, M.D. 9801 Georgia Ave.# 341, Silver Spring, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 2004 Registrar

06.15 AM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Louise Coleman Thomas August 21, 6:15 a^M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√□ F 82 579-12-9783 Yrs. Director 1922 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ir than "natural", or items 23a or 28e-f sho the Medical Examinar must be notified at 1 X Yes 2 No Woodbine Director Maryland Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21797 USA 3209 Brighton Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural; or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Telephone Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Lenore Durrette Benjamin F. Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 Brighton Court; Woodbine MD 21797 Robert A. Johnson - Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition n place) 1 

Burial 2 □ Cremation 3 □ Removal from State 8/26/2004 permit. Page Department of Importent: If any injury or once. Fort Lincoln Cemetery Brentwood, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Mylin T. Wobert 3401 Bladensburg Rd; Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit and Due to (or as a consequence of): Box 68760 ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 To the Hospitel or Attending Phywithin 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral is 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 123308 pers who completed cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE D.1. #4100 BETMESDA, MD 20817 31. Date filed (Month, Day, Year) AUG 2 5 2004 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

# Christophyluelzer

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Box (
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Records
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					C	ertifica	ate o	f Death		Re	g. No.	16	281.9	
	1. Decedent's Name (First	t, Middle, Las	st)	-						2. Date of Death		/Year	3. Time of De	
	Christopher William Wuelzer								8	20/	2004	1127		
ı	4a Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CE								wn, or Loca LISBU	ation of Death	4c. County	of Death	0.	
ļ	PENTINSULA  5. Social Security Number			AL CE		(au) If Unc	der 1 Yea						ice (State or Fo	
	228-45-3947	7	□ M 2□ F	24	Yrs	Month	ns Day		Min.	B. Date of Birth (Month, Day, Feb 19		Counti	lodrado	
-	Usual Residence of Deced 10a. State 10b.	County		10c. Cit	y, Town o	r Location						10	d. Inside City L	
	VA	Acco	mack	()	hine	otec	agu	C					1 ★ Yes 2	
	10e. Street and Number						Zip Code			10	Og. Citizen of	What Countr	y?	
	6250 Mumford	Street						2333	36			U.S.A		
	11. Marital Status		12. Was Decedent Armed Forces	?	,S. ·	13. Was Dec	cedent or pecify Cu	f Hispanic Original	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ce - America		
	1 ☑ Never Married 2		1 ☐ Yes 2 🔀		1 ☐ Yes 2 ☐ No Specify:					Specify:				
	3 ☐ Widowed 4 ☐ Di	ecedent's Ed	Year or Dates:		160 0	ecedent's U	sual Occ	unation			16b. Kind of B	V	hite	
	(Specify only	y highest gra	de completed)	F.\	(G	ive kind of the DO NOT	work don	e during most	of working				•	
	Elementary/Secondary (	(0-12)	College (1-4or	<b>5+)</b>			C	arpenter	enter		Wue	Wuelzer Construction		
		7. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	First, Middle, N	lle, Maiden Surname)			
		Ronald	Wuelzer									ie Hardin		
	19a. Informant's Name/Re		ype, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Lorie Terry Mother 7129 Bunting Road Chincoteague, VA 23336  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City of Disposition (Name of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Location - City of Date 20c. Locatio							City of Tow	m State						
1 A Burial 2 ☐ Cremation 3 ☐ Removal from State   Cemetery, crematory or other place)														
4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee					M	echanic 22 Name		netery_ lress of Facility		193/04	Chi	ncoteag	ue, VA	
amanda C - Botto					Salyer Funeral Home 6327 Church Street Chincoteague, Virginia 23336									
-	- ·		-	d the deat	h. Do not		6327	Church St	reet Ch	nincoteagu	e, Virginia		Approximate	
	23a. Part1. Enter the dise shock, or heart failur	e. List only o	one cause on each I	ine.			1	, 3.		, ,			nterval Betwee Onset and Deal	
	Immediate Cause (Final disease or condition			2	tir	L	ho	6				1		
	resulting in death)		a	Due to (o	or es a con	sequence o	of):					1		
			b	neu	m	one	a					,		
Sequentially list conditions, if any, leading to immediate														
Cause (Disease or injury														
that initiated events resulting in death) Last Due to (or as a consequence of):														
			d		-									
	Part II. Other algnificant c	onditions co	entributing to death b	out not resi	ulting in th	e underlying	g cause o	given in Part I.		23b. Did tol	Dacco use col	ntribute to t	he cause of de	
					_	., ., .,					s 2□No		/	
	- CCCO	rece	iufa	ui.	a									
	alcoh	10%	in Ca	les	ta					24a. Was an perform	autopsy ied?	24b. Wer	autopsy findi able prior to pletion of caus	
	700-0										1	of de	pietion of cause eath?	
										1 ☐ Ye	a TIZNO	1 🗆	Yes 2□ No	
	25. Was case referred to r examiner?	-	Hospital:							Check only one				
	1 ☐ Yes 2 ☑ No 27. Manner of Death		14 Inpati	ent 2 🗆	ER/Outpa 28b. Tim		DOA 28c Ini	4 □ Nur		5 ☐ Resider				
	1 ØNatural 5 □	Pending investigation	28a. Date of Inju (Month, Da	y Year)	Inju	y M	28c. Inj W	ork? □Yes 2□N	115		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		
	3 Suicide 6 □	Could not be determined	28e. Place of In	jury - At ho	ome, farm,	street, fact	tory, offic	В	28	f. Location (Str	eet and Numb	er or Rural i	Route Number,	
ŀ			i building et	c. (Specify	y)					City or Town,	State)			
	4  Homicide		ballaling, of											
2	29a. Certifier	ertifying Phy	vsician: To the best	of my know	wledge, de	eath occurre	ed at the	time, date and	l place, an	d due to the ca	use(s) and ma	inner as stai	ed.	
	29a. Certifier	edical Exam		f examinat	wledge, de tion and/o	rinvestigation	on, in my	time, date and opinion, death	l place, an h occurred	at the time, da	use(s) and ma te and place,	and due to t	he cause(s)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or. Simona Eng | W.E. Carlot | S7

31. Date filed (Month, Day, Year)

AUG 2 4 2004

32. Registrar's Signature

40057412

			Flease	State of Manus								
			For State	State of Maryla	•	rtificate of			2001	281.07		
			Registrar  1. Decedent's Name (First, Middle, Las.	")		runcate or	Death	2. Date of Dea	Reg. Na. UUU	3. Time of Death		
and or	Physici /Medic		Joseph	B-	w	illiams		Augus		1 05:06 AM		
1	Examir	er	4e. Fecility Name (If not institution, give	4 4		7.	or Location of Death	1.	4c. County of De	ath .		
			The Johns H 5. Social Security Number 6. Se	opkins Hos	PITAL last birthday)	BAH in	If Under 24 Hrs.	8. Date of Birtl	h 9.8	irthplace (State or Foreign		
ı	Funeral Director		205-44-5508	X ^{M 2□ F} 50	Yrs.	Months Days		8. Date of Birth (Month, Day May 2,	1954 Wa	Country)		
	p _		Usual Residence of Decedent									
	arylar show	_	10a. State 10b. County		City, Town or Lo							
	Ba-f	ecto	MD Char	les	La Pla				10- 02:			
	with t	Funeral Director	10e. Street and Number 812 Washingto	n Ave.		10f. Zip Code	646			ountry?		
	leath	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		Hispanic Origin? (Spi an, Mexican, Puerto	ecity Yes or No-		rencan Indian,		
36	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-1 show In Medical Exertinar must be rodified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Λ Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 XNo		Rican, etc.)	1			
8	tural	edb	15. Decedent's Ed		16a. Dece	dent's Usual Occur	pation		16b. Kind of Busines	s/Industry		
57	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work dorie DO NOT use retire	pation during most of work d)	ing		,		
2	filed with Hygiene other tha	E	Clotheritary/Occordary (0 12)	4	En	gineer			Radi	.0		
	o la b	To Be (	17. Father's Name (First, Middle, Last) Edward Bennett	Williams			18. Mother's Name Agnes N		Maiden Sumame)	10d. Inside City Limits   1		
ary	2 should I and Meni Is marke	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Run	ai Route Numbe	r, City or Town, State,	Zip Code)		
	and 2 fealth a m 27 ls		Sharon Williams	/Wife	812	Washin	gton Ave	. La I	Plata,MD	20646		
ore	ges 1 and to the life it of the or other		20a. Method of Disposition  Burial 2 Cremation 3		cemetery, cre-	matory or other pla	ce)	Date				
Ĕ	Pa ment: ury		'4 □Donation 5 □ Other (Specify	) 5		Heart C	em. 8/24	1/04	La Plata	, MD		
Baltimore,	permit. Page Department o Importent: If any Injury or once.		21. Signature of Funeral Service Licen:	Ehrl)	0945							
K			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the d	eath. Do not en					Approximate		
1	Physician		Immediate Cause (Final disease or condition	Raland	DIC. 1	hu nove.	000.0					
	/Medical		resulting in death)	a. Die to (or as a cons	sequence of):	ny pox	2MIH			Samys		
В	Examiner		Sequentially list conditions,	b. Theumo						Imonth		
	p sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):		1		-1			
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760,	te be executed ysician and te burial-transit		· ·				1	•				
687	ficate p phys is the	edlc	•	d								
Box	death certificate k e attending physis d for use as the b	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		75			23d. Date of d	alivery		
	0 0 0	Physiclan/Medical	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year		
P.O.	ac ac	hys	9 🗆 Unknown									
		by	Part II. Other significant conditions of	intributing to death but not	resulting in the u	inderlying cause gr	ven in Part I.	4.4				
ord	een s	ted			<del></del>			'A'	es 2 No 3 1	robably 4 Unknown		
ec	The law requires te has been sign page 2 should be	Completed						24a. Was autop	sy prior to	completion of cause of		
ᆵ								1 Yes				
Zi K	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🥦	(TED/0 · · · ·	Ott	26. Place of Deat					
of	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	II 3LI DOA	4   Nursing no		ence 6 Other (Sp low injury occurred	ecify)		
Division of Vital Records,	Attending F r death. ector: After by the funer	tlo.	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Yeer	) Injury		rk? ]Yes 2□No					
Visi	or Attendated Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, st	reet, factory, office		28f. Location (S City or Ton	Street and Number or I	Rural Route Number,		
Ö	tal or A	Cert	7	building, etc. (op.				0.19 01 7011	ni, State)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the	edicai	29a. Certifier 1 Cartifying Phyone (Check only one) 1 Medical Example 1	rsician: To the best of my inar: On the basis of exam and manner stated.	knowledge, deat iination and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the deed at the time, d	cause(s) and manner added	is stated. ie to the cause(s)		
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mor	nth, Dey, Year)		
	2 0	5	Anson fr	half		R	25 - 600	1	August 2	0, 2004		
			30. Name and address of person who o	completed cause of death (	item 23a) (Type,	Print)				20, 2004		
1	P 10		Dusan Ger	hardt 18	330 Mo	west	St. Bu	Himor	i mo z	41205		
16	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Snorth a						

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			For State of Maryland / State Registrar	Department of Health and I Certificate of Death		ene	20100	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death	
	Physici /Medic		MARY HELENA WONG		AUGUST	20 2004 10:00 P ^M		
	Examin	er	4a. Facility Name (If not institution, give street and number)  SOLOMONS NURSING CENTER	4b. City, Town, or Location of Death SOLOMONS	1	4c. County of Death  CALVERT	1	
	Funeral		5 Social Security Number 6. Sex 7. Age (In vrs. last t	pirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)	
١.	Director		577–18–5049 1 N 2 KF 87	Yrs. Months Days Hours Min.	OCT. 19	,1916 NOR	TH CAROLINA	
	and wo		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location			10d. Inside City Limits	
	Mary Illed	tor	MD ST. MARY'S MECHA	NICSVILLE			1 ☐ Yes 2 X No	
	or 28s	Direc	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?	
	death with the Maryland ms 23a or 28a-f show	ral	27465 EVANS BUCKLER LANE  11. Marital Status 12. Was Decedent Ever in U.S.	20659	pecify Ves or No-	U. S. A.	ican Indian	
"	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene Item 27 is marked other than "natural", or items 23a or 28a-1 show Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at	Funeral Director	Armed Forces?  1 Never Married 2 Married 1 Yes 2 M No	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White		
215-0036	hours after tural', or ite al Exemina	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:			HITE	
15-(	n 72 h "natu	lete	(Specify only highest grade completed)	<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)</li> </ul>	king	6b. Kind of Business/l	ndustry	
212	d within jiene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ESTAURATEUR	I	RESTAURANT		
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	Bec	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma			
Maryland	d Mental	2	OTTO POUNDERS  19a. Informant's Name/Relationship (Type, Print)  15	DUNN LE  Ob. Mailing Address (Street and Number or Ru	BLEMMONS		in Code)	
Z	ulth an 27 is r			7465 EVANS BUCKLER LA		•		
Je,	es 1 and 2 of Health of fitem 27 is		20a Method of Disposition 20b. Place			Oc. Location - City or 1		
ii	Page ment tant: If		`4 □Donation 5 □ Other (Specify) BRINS			IARLOTTE HA		
Baltimore,	permit. Pages Department of 8 Important: If Ite any Injury or o		21. Signature of Funeral Service Licensee  M0064	22. Name and Address of Facility BF 30195 THREE NOTCH R				
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ese:		01100t and Doda!	
	Examiner		Due to (or as a consequence	of):				
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):				
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence	e of):				
8760,	icate be executed physicien and s the burial-transit	alE	200.10 (01.00.2.00.100420.10	· · · · · · · · · · · · · · · · · · ·				
687		ledical	<u> </u>					
Вох	death certific e attending p ed for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deal			23d. Date of delivery	very Day Year	
	0 0 0	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)			,	
, P.O	requires that the de een signed by the a nould be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ords	w require been sig should b	ted b	Chron C Obstructive pul	monary on seas	2 1 ☐ Yes	2 No 3 Pro	bably 4 Unknown	
ecc	aw as b	Completed	Atrial fibrillations	U	24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of	
a H	Th ete pag		25. Was case referred to medical	00 Plans (Pass		No 1 ☐ Yes	2□ No	
of Vital Records,	Phyalclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/C	Othor		ce 6 □Other (Spec	ıfy)	
n of		J: L	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b	. Time of 28c. Injury at Injury Work?	28d. Describe how	injury occurred		
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Stre	et and Number or Ru	ral Route Number	
Div	after after I Direct	Certification:	4 Homicide determined 228. Flace of mindy skillotte, building, etc. (Specify)	iami, street, ractory, onice	City or Town,	State)		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1					
	To the within To the	Me	29b. Signature and little of centifier	29c. License number	290	d. Date signed (Month	, Day, Year)	
			MD MD	D059400	A	UGUST 23,	2004	
,	wo 2		30. Name and address of person who completed cause of death (Item 28 a SSA YUSUF 110 HOSPIT	(Type, Print)	03 Pru	ce Frank	Perick MD	
1	MP 2 Sta	te	31. Date filed (Month, Day, Year) AUG 2 4 2004  32. Restrar's Signature	1	, 1501	1000	, ,	
	Registr	_	AUG 2 4 2004 Miseur A	F ANDERS				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:15P August 17,2004 J. Latimer Watkins /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year **Funeral** 1**X** M 2□ F Director 95 13, 1909 Mary Land 146-10-5582 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Exercities must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 28440 Honeysuckle Drive 20872 U.S.A. Items 23a within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: δ 3 1x Widowed 4 □ Divorced White "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) Merchant Variety Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I John S. Watkins Melissa Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 Arlene Tressler - Executor 8129 Ball Road, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H-Important: If Iter any injury or oth 2 Cremation 3 Removal from State 1 X Byrial Oakland Cemetery Aug. 22, 2004 Indiana, Pennsylvania 4 □Donation Other (Specify) 21. Signature of Funeral Service Licensee Olin L. Molesworth P.A., Funeral Home once. overt 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Olonic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Is signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 GNo 3 ☐ Probably 4 ☐Unknown cate has been sig , page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 21 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 1 Tes 2 Ne Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel or 24 hours a Funeral L 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 To the the 29b. Signature and title o 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O. 1

Division of Vital Records,

30. Name and address of person

31. Date filed (Month, Day, Year)

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ath (Item 23a) (Type, Print)

Ve.

0 2004

32. Registrar's/Signature

			4 44.	artment of Health and Me		g. No. 0 0 1	28500
	Physici	an	Day Ye.	3. Time of Death			
-	/Media	ai	Morgan Raymond Webber  4a. Facility Name (If not institution, give street and number)		August	22, 2004	3:20 P. M
	Examir	er		4b. City, Town, or Location of Death		4c. County of D	
	Funeral		3706 South Mountain Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Knoxville    If Under 1 Year   If Under 24 Hrs.   8	. Date of Birth		erick Birthplace (State or Foreign Country)
	Director		213-16-0470 ^{1⊠M 2□F} 84 Yrs.	Months Days Hours Min.	(Month, Day, une 19,		Country) Maryland
	p ≥		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L				
	larylan show	5					10d. Inside City Limits 1X Yes 2 □ No
	the Maryla 28a-f shov	Director	Maryland Frederick Knoxvil	Le 10f. Zip Code	10	g. Citizen of What	
	th with 23e or	ä	3706 South Mountain Road	21758	10	United S	•
	death with the Maryland rms 23e or 28a-f show	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - A	merican Indian,
9			1 Never Married 2 Married 1 1 Yes 2 No	37	can, etc.)		hite, etc.
333		d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🖺 No Specify:		Specify:	White
Maryland 21215-0036	72 hours "neturel",	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation Is kind of work done during most of working DO NDT use retired)	1	6b. Kind of Busine	ss/Industry
12	withir ane. <b>then</b>	ш	Elementary/Secondary (U-12)   College (1-4or 5+)	ar Inspector		Railro	nad
d 2	s tited withir I Hygiene. other then	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	First Middle Mi		du
an	d be ental ced o	To B	Clarence R. Webber	,			
ary.	ges 1 and 2 should be lited within to the Health and Mental Hygiene. If item 27 is marked other ther or other treumetic event, Illiu Meres other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other treumetic event, Illiu Meres or other or other treumetic event.	-		Mary Lou I ing Address (Street and Number or Rural F		City or Town, State	a, Zip Code)
	alth a			Hoffmaster Rd. Knoxy			
J.	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disp			c. Location - City	or Town, State
Ē	Page nent c			e Reformed 8-27-0	4 K1	noxville,	, MD
Baltimore,	permit. Page Department of Importent: If any injury o		21. Signatur of Funeral Service Licensee 2	2. Name and Address of Facility Stat	ıffer Fı	ıneral Ho	ome.
<u> </u>			Journy Stanfage	1100 North Maple Av	ze. Bri	ınswick.	
			23a. Part 1. Enter the decase, or complications that caused the deeth. Do not en shock, or heaft tallure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Heart July	use			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	feart disease			
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8760,	ate be execul physician and the burial-trar	dicai E	( a				
9	ificate g phys	edic	u				
Box	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75-4		23d. Date of c	delivery
	deatle atte	icia		Dectopic pregnancy Other (specify)		Month	Day Year
P.O.	at the by th	hy	9 Onknown				
	es thi gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	pluoi bluoi	ted	June Julie		1 🗆 Yes	2.D€No 3□	Probably 4 Unknown
Ö	faw ras be	npie	•		24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
= =	The	Completed by			performe 1 ☐ Yes 2	d? death No 1 □ Y	?
Vita	icien Sertition Sector	Be	25. Was case referred to medical examiner?	26. Place of Death (C			
of	Physicien: this certition	. To	1 Impatient 2 EH/Outpatien			e 6 □Other (Sp	pecify)
u	ding h. Atter fune	tion	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at 28c Work? M 1 □ Yes 2 □ No	I. Describe how	injury occurred	
Division of Vital Records,	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st		Location (Stree	et and Number or	Rural Route Number,
Ω	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely tilled in by the funeral director, page 2		29a. Certifier Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and	due to the cau	se(s) and manner	as stated.
	ne Ho	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date	and place, and d	ue to the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mo	nth, Day, Year)
)			Em thee my	17608		8/33/0	4
_i	17+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		-/-/-	1
(	0+1		Dr. Elinor Hill 1101 Opal Court H	agerstown, Maryland	21742		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 Anadi			
	Registr	all	AUG 2 5 2004 Seneva	~ jujuns			